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Illustrations OF HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

KING'S COLLEGE HOSPITAL.

FEMORAL HERNIA: OBSTRUCTION OF THE BOWELS FROM ADHESION WITHIN THE PERITONEAL CAVITY.

Under the care of W. BOWMAN, Esq.

[*From Notes by* J. WALTERS, Esq., *House-Surgeon.*]

IT may be interesting to compare the two following cases together, in each of which a hernia existed together with such symptoms as might have been produced by its strangulation. It was not difficult in either to arrive at the conclusion that the hernia was not the cause of the symptoms of obstruction, though, in Mr. Johnson's case, as the swelling was irreducible, it was thought better to make an exploratory incision. This having shown that the disease was not accessible without a more formidable operation than, in her weak state, she would have survived, it seemed unjustifiable to proceed further, or to trouble her by a more elaborate examination; otherwise, the situation of the disease, just below the hernial tumour, was such that a slight extension of the incision would have brought it within reach, and the gut might have been opened above the tumour. The case offered a good example of the fact that the peritoneal coat of the intestines is the least extensible of their tunics, and gives way to a much greater extent than, or even before, the muscular structure. It is also the only instance we have met with of an appendix epiploica being so large and prominent as to cause a distinct hernial tumour.

Mary D., aged 74, was admitted in the evening of January 19th, under the care of Mr. Bowman. Some years ago, she had two inguinal ruptures, on which account she wore a double truss. One week before admission, a lump appeared in the right femoral region, attended with pain and uneasiness. During this week, the bowels were open three times, pain and nausea being constant. She was seen by a medical man the day before admission, who recommended her to go to a hospital, for the purpose of having an operation performed. On her way thither, the swelling (which was supposed to be a strangulated hernia) nearly disappeared; and, on her admission, a small tumour, about the size of a walnut, was all that was left, situated over the right femoral ring. This evidently contained no gut. It was easily reduced, and as readily returned, when the pressure was removed. Still, however, vomiting continued, though she said she had no pain.

Next day, the pulse was weak, and the stomach so irritable that even a teaspoonful of brandy caused vomiting. She took no food, and did not sleep. She had an enema in the morning, and one again in the evening; and the bowels were open slightly after each.

On February 21st, the vomiting ceased. She lay almost insensible, sank rapidly, and died in the evening.

On *post mortem* examination, the body was found to be well nourished. In the upper lobe of the left lung was a small circumscribed mass of tubercle, of long standing; and the lung was here adherent to the walls of the chest: otherwise, the thoracic viscera were healthy. The left kidney was natural; the right was surrounded by a quantity of pus, apparently formed originally in the renal structure. The kidney itself was infiltrated with purulent matter, and little or none of the secreting structure could be found. Much of the matter had become solid, like cheese, forming pellets about the size of a mustard-seed. The intestines were in many parts congested, but did not present anywhere marks of constriction. There was, however, a small portion of omentum which entered the right femoral ring, but was not strangulated. The uterus presented upon its surface and in its substance several tumours of a fibrous nature, with spiculæ of false osseous matter. The ovaries were also enlarged, and, upon section, presented a number of small masses of ossification, probably spurious. They were surrounded by firm fibrous tissue. This diseased condition had probably set up a local inflammation; for closely connected to the ovaries were several coils of intestine, both large and small, bound down by firm bands of lymph, which had so contracted their canals that water would scarcely pass through them; yet, upon carefully dividing the strictures, the intestine was found healthy in every respect. No great amount of distension of the intestines by flatus above the points of constriction appeared, but their contents were quite fluid.

ST. GEORGE'S HOSPITAL.

I. UMBILICAL HERNIA: OBSTRUCTION OF THE BOWELS FROM MALIGNANT DISEASE.

Under the care of H. C. JOHNSON, Esq.

[*From the Hospital Case-Book.*]

REBECCA P., aged 56, was admitted on December 15th, 1858, under Mr. Johnson's care, with symptoms of obstruction of the bowels, which had lasted about ten days, though she had taken all kinds of purgative medicines. She had had constant vomiting for several days. She complained of great pain over the abdomen, principally around the umbilicus; at which part was a small hard tumour, about the size of a marble, which was rather tender on pressure. She was in an excessively low state; the pulse small and quick; the tongue much coated. An incision was made down to the tumour, and the peritoneal cavity was opened, when a small piece of fat was found lying in the ring of an old umbilical hernia. This was cut off, and no further examination of the abdomen made. Ten grains of calomel were placed upon her tongue, and half a drachm of laudanum given in the evening; but she continued to vomit everything she took, and died next morning.

The abdomen was examined after death. The incision made during life was found to extend into a small moveable lump of fat, situated just below the skin. On opening the peritoneum, a quantity of offensive gas escaped. A large quantity of fæcal fluid was found in the peritoneal cavity. The peritoneum was not vascular. This fluid had escaped from a perforation in the gut near the commencement of the transverse colon. The cæcum was enormously distended, and was raised up from the iliac fossa, so as to lie across the middle line, in the right lumbar and umbilical regions. The mass of fat which projected into the wound was found to have been a long appendix epiploica, which was growing from a part of the gut near the part perforated. All the appendices epiploicæ were unusually long. At the seat of the perforation, the intestine was enormously distended, and its peritoneal coat had been torn for a long distance. The perforation, in its natural condition, was only of small size; but, in injecting water into the gut, it gave way readily. No extra vascularity seemed to exist around it. Immediately below this part, the colon was compressed by a large tumour, apparently of the hard encephaloid nature, which united it firmly to the liver, and projected beneath its mucous membrane as a ring of tubercular elevation, closing the gut so completely that water would not pass through it.

II. VESICO-VAGINAL FISTULA: TWO OPERATIONS: DEATH FROM ANOTHER CAUSE.

Under the care of G. D. POLLOCK, Esq.

Eliza Fuller, aged 36, was admitted into St. George's Hospital, originally, in June 1858, under Mr. Pollock's care, on account of vesico-vaginal fistula. She was said to have been

married at the age of 14, but never to have had a child till twenty-two months before admission. She was left in labour on that occasion for four days and nights, and ultimately delivered by craniotomy. Ever since that time, she had had complete incontinence of urine, and had suffered occasionally from attacks of inflammation of the bladder. She was kept under treatment on this account for some weeks after her admission, and also from the loss of appetite and constitutional weakness under which she laboured; and, when she was somewhat improved in these respects, the first operation was performed on August 12th. The cleft, having been exposed, was seen to be of very large size, so as to allow the protrusion of a portion of the mucous membrane of the bladder as large as a walnut. It was situated at the anterior part of the base of the bladder, extending forward nearly to the urethra. The urethra itself was considerably constricted; but, after some little difficulty, a full sized catheter was forced into the bladder. The edges were then pared, and the cleft brought together in the usual way with Bozeman's button and six silver sutures, longitudinally. The operation was necessarily a protracted one, and she was left under chloroform for an hour, but seemed to bear it tolerably well.

The cleft was examined for the last time on September 16th. It was then found to have united by first intention in front to some extent, but an orifice remained behind, through which the mucous membrane of the bladder protruded.

She was sent out of the Hospital on October 17th, for the benefit of her health; and was readmitted in January 1859. She then reported that her condition had not been improved by the operation, as all the urine still ran away. On examining the opening, it was found much larger than after the operation, measuring about an inch and a half in length, and rather more than that in breadth.

The operation was repeated on January 13th; eight silver sutures being used, and the line of union made transverse. She was kept under chloroform for more than an hour.

January 15th. It is noted that she was low and weak, and had no appetite. She did not complain of pain in the abdomen.

January 24th. She still remained in a low state, drowsy, and disinclined to answer questions. The tongue was dry and red; the urine copious, alkaline, containing some mucus, but no albumen. The plate was in position, and everything looking well about the wound. No cause was discovered for her symptoms.

January 29th. She had rigors, and there was said to be a purulent discharge from the rectum. The urine was fœtid and alkaline. The catheter was removed, the shots cut from the sutures, and the shield taken away. A small part of the cleft was found ununited. She gradually sank into a half-unconscious state, without any more prominent symptoms; and died, comatose, on February 4th.

On *post mortem* examination, it was found that the peritoneal cavity was perfectly healthy. The fatal disease appeared to be situated in the kidneys, one of which was much atrophied, and the pelvis of the kidney on one side occupied by a number of renal calculi. One of these calculi had passed down into the bladder.

The parts concerned in the operation presented the following appearance: The bladder was small and healthy in structure, except at the fundus. Here was a small cleft, about half an inch in length, which extended into the vagina, and on either side of which there was a transverse cicatrix—the trace of the second operation. No traces of the first operation were visible in the bladder. The bladder contained a small oval calculus, which might have easily passed through the cleft, and which, therefore, was supposed to have been in the bladder for no very long period. In the vagina, the traces of the operation were more perceptible. Extending forwards longitudinally from the cleft to about a quarter of an inch from the urethra was a linear cicatrix about three quarters of an inch in length, which was, in all probability, the result of the first operation. The line of union from the second operation was marked both by an irregular transverse scar, and by the presence of four of the silver sutures, which had not been interfered with since the operation, and which remained in the mucous membrane of the vagina, without appearing to produce any irritation, at least there was no trace of ulceration around them, although the whole surface of the vagina for some distance around the cleft was covered with a leathery exudation, easily removed. One of the silver sutures had very nearly cut itself out, but the line of its ulceration had been closed as rapidly as it had been formed, and was quite imperceptible.

Remarks. The above case is not adduced as a fatal case of operation for vesico-vaginal fistula, inasmuch as death was the result exclusively of the visceral disease, and could only have had a remote, if any, connection with the operation and its accompaniments. In fact, as far as the case bears upon the prognosis of the operation, it is favourable to it; as showing how great an amount of union may be procured, by the method of operating now adopted for this distressing malady, even under the most unfavourable circumstances, where the cleft is of extraordinarily large size, and the patient in the worst condition of health. The case is also of interest as showing the great advantage of the metallic over vegetable sutures. There can be little doubt of the advantage, in cases where union by the first intention is sought, of a method which holds the parts is close apposition without producing any excessive amount of inflammation along their edges; while in less favourable cases, where fluids have insinuated themselves between the edges of the wound, and union by the first intention has failed, it may still be possible for the cleft to granulate up and become closed by a process of cicatrisation when kept in close union. Too many instances of this have been seen in operation for vesico-vaginal fistula to allow of any doubt on the subject.

Original Communications.

THE STOMACH AND ITS AILMENTS PRACTICALLY ARRANGED.

By W. S. Oke, M.D., Senior Physician of the Royal South Hants Infirmary.

[*Read before the Southampton Medical Society, Nov. 7th*, 1858.]

[*Concluded from page* 192.]

VIII.—Hæmorrhagic Condition of the Stomach.

Hæmorrhage from the stomach may be the result of several causes, viz.: 1. Ulceration, simple or carcinomatous; 2. A cachectic state of the system, evidenced by a pale aspect, petechial spots on the skin, foul breath, loss of appetite, and great debility; 3. Gastric plethora, produced in females by a deficiency of the uterine monthly secretion, or in other cases, by an obstruction of the portal veins as they pass through the liver. In the hæmorrhagic condition from deficient menstruation, the blood is often thrown up monthly in moderate quantities when the catamenia should appear; it is fluid, and of the colour of port wine and water: when the hæmorrhage arises from portal obstruction, the quantity lost is profuse, sometimes amounting to a quart at a time. The blood is venous and coagulated, and the hæmorrhage may take place at any time. This kind of gastric hæmorrhage may be produced either directly or indirectly: directly, when the gastric capillaries are overcharged with blood and weakened by the constant application of strong stimuli in excessive drinking; indirectly, by such stimuli setting up an increased and morbid action of the hepatic artery, which eventually produces an organic disease in the parenchyma of the liver, obstructing the portal trunks, and by consequence the gastric veins, which in part enter into their formation. As the gastric veins become more and more distended, they pour their contents into the cavity of the stomach sometimes to the large amount of blood above stated. The plethoric state of the stomach, before the gastric veins have disgorged their contents, may be diagnosed with tolerable accuracy. There will be a diffused, but not *hard* enlargement of the epigastrium, painful under firm pressure; the diaphragmatic breathing will be short and impeded; and the heart's action irregular, with a sense of weight in the region of the stomach. If, along with these symptoms, there should take place a sudden feeling of giddiness, faintness, falling of the pulse, and a pallor of the countenance, we may be assured that hæmorrhage is going on into the stomach, and that vomiting will presently follow, bringing up a large quantity of blood, of a dark colour, and more or less coagulated. Considerable relief will now be felt at the region of the stomach; but the patient will become pale, debilitated, and greatly alarmed. Gastric hæmorrhage from this cause is profuse, not only from the internal heat of the body, but from the blood issuing from veins that have no valves to modify the quantity lost. When the extravasated blood finds its way also into the intestinal canal, which it usually does, it appears in the stools in considerable quantities, and when mixed with bile is sometimes the

colour and consistence of tar, which has caused the disease under such circumstances to be termed melæna.

1. Gastric hæmorrhage from simple ulceration may occur in very early life. I saw one instance in an infant under six months old, which resisted all treatment and terminated fatally. On examining the stomach after death, the hæmorrhage was ascertained to have issued from a small superficial ulcer of the mucous coat. The treatment of this case is very difficult, even in the adult, from the ulcer being kept open by the constant digestive actions of the stomach. It may be sufficient to treat the ulcer with a light and soothing diet, such as dilute milk and barley water, panada, whey, and the like. If this should not succeed, and the patient be an adult, small doses of calomel may be given with opium as in (*a*).

a. ℞ Hydrargyri chloridi gr. vj; pulveris opii gr. ij; confectionis rosæ ℈ij. Misce, et divide in pilulas xij quarum capiat i ter die.

Should the hæmorrhage not yield to this treatment, a dose of (*b*) may be given with each pill.

b. ℞ Argenti nitratis gr. iij; acidi nitrici diluti ʒj; aquæ rosæ ad ʒvi; syrupi rosæ ʒiii. M. Sumat ʒss cum quâque pilulâ.

2. When the hæmorrhage arises from debility, the indication is simply to strengthen the vitality of the blood; and this will best be done by mineral acids and other tonics, as in (*c*).

c. ℞ Acidi hydrochlorici diluti ʒiss; syrupi zingiberis ʒiii; infusi cascarillæ ad ʒviii. M. Sumat ʒi ter quotidie.

Should (*c*) not be retained, (*d* or *e*) may be substituted.

d. ℞ Acidi nitrici diluti ʒiss; syrupi aurantii ʒi; tincturæ opii ʒss; aquæ destillatæ ʒviii. M. Capiat cochlearia larga ij ter quotidie.

e. ℞ Acidi gallici ʒss; confectionis rosæ q. s. M. Divide in pilulas vj, quarum capiat i ter die.

The diet must be generous: strong beef-tea and a pint of port wine daily. Should aperients be required, small doses of castor oil are to be preferred.

3. When gastric hæmorrhage arises from a deficiency of the uterine secretion at the monthly periods, it must be considered as vicarious, and looked upon more as a remedy than a disease; nevertheless, if profuse, the indications are first to restrain the gastric hæmorrhage, and then to restore the uterine discharge. The first will best be fulfilled by (*f*), and the second by (*g*).

f. ℞ Magnesiæ sulphatis ʒvj; acidi sulphurici diluti ʒj; syrupi aurantii ʒss; infusi rosæ compositi ad ʒvj. M. Sumat ʒj mane et meridie.

g. ℞ Misturæ ferri compositæ ʒviii; decocti aloës compositi ʒiv. M. Capiat ʒi bis terve die.

The mixture (*g*) should be continued till the uterine secretion is restored.

In hæmorrhage from obstruction of the portal veins in the liver, which is most commonly the cause, it will always be best, if possible, to treat it in the plethoric stage before any hæmorrhage has taken place; the symptoms of which have been described, but the success of the treatment will in great measure depend upon the structural change which has taken place in the liver. If this organ be enlarged or shrunk from a long established practice of excessive drinking, especially of ardent spirits, the disease will be incurable in a large majority of cases from the obstruction to the portal system being permanent; but if the symptoms be those of gastric plethora antecedent to hæmorrhage, the first indication is to relieve the turgid state of the gastric veins; and as these form a considerable part of the portal veins, they will best be relieved by bleeding the hæmorrhoidal veins in the following manner: as many leeches as may be deemed necessary (say six) having been applied to the margin of the gut, the patient is to be seated on a night-table over a pan two-thirds full of almost boiling water, with a pint bason, containing a tea-spoonful of salt steadily floating upon the centre, to receive and empty the leeches as they fall off, and to catch the blood as it distils from their bites. The vapour of the hot water will encourage the bites to bleed, whilst the contents of the bason will show the exact quantity lost. This is, perhaps, the most satisfactory method of bleeding the hæmorrhoidal veins by leeches, to relieve the plethora of the portal and gastric veins. When hæmorrhage has taken place, all warm fluids should be avoided, and all fluids that are drank are to be iced, such as currant jelly and water, lemonade, or orangeade; fruit ices also may be eaten in small quantities till the hæmorrhage has ceased, after which the mixture (*h*) may be commenced, and repeated every four hours till the bowels are acted upon.

h. ℞ Confectionis rosæ ʒi; infusi rosæ compositi ʒvj. Misce et cola: dein adde magnesiæ sulphatis ʒvj; acidi sulphurici diluti ʒi. M. Capiat ʒi quartâ quâque horâ.

And, with the view of clearing the liver, four grains of blue pill may be given every night.

After the hæmorrhage has completely ceased, an attempt should be made to remove that condition of the liver which has obstructed the portal veins, and with this view the pills (*i*) may be commenced.

i. ℞ Pilulæ hydrargyri gr. xviij; extracti conii gr. xviij. Misce, et divide in pilulas xij, quarum capiat unam ter quotidie.

And subsequently the mixture (*j*).

j. ℞ Hydrargyri bichloridi gr. ij; ammoniæ hydrochloratis gr. xxx; tincturæ cardamomi compositæ ʒi; aquæ menthæ piperitæ ad ʒvj. Misce. Capiat ʒi ex aquæ menthæ piperitæ pauxillo ter die.

At the same time, a blister may be applied to the epigastrium, and kept open with the following epispastic ointment.

℞ Emplastri lyttæ ℈ij; unguenti resinæ flavæ ʒj. Misce.

The savine ointment is not sufficient for this purpose.

IX.—Inflamed Condition of the Stomach.

Inflammation of the stomach is not of frequent occurrence, and may be practically divided into peritoneal gastritis and endogastritis. In the former, the disease attacks the outer or serous, in the later, the internal or mucous coat; but it must be admitted that it is scarcely possible for one coat to be attacked without the others being involved in the disease. Nevertheless, in a practical point of view, it is important that the membrane primarily affected should be correctly diagnosed.

In peritoneal gastritis, the disease is ushered in by rigors, either associated with or quickly followed by acute pain of the epigastric region, vomiting, and the ordinary symptoms of sthenic pyrexia. In a few hours, the pain is greatly increased, and the tenderness is so exquisite as to be aggravated by the slightest pressure, or any movement of the trunk of the body, especially in rising from the horizontal to the sitting posture. The febrile heat now increases with the disease; the pulse rises to 120 in the minute; the tongue is furred; there is great thirst; and frequent vomiting, which is most distressing to the patient. Should the disease increase, the abdomen becomes tympanitic, and the area of the tender surface is rapidly extended. There is also serous fluid, mingled with shreds of plastic lymph effused into the peritoneal cavity; and the abdomen becomes dull under percussion, and intolerant of pressure throughout: in short, the case becomes that of peritonitis, and, if the symptoms be not relieved, the patient often succumbs on the seventh or eighth day.

Endogastritis is characterised by the pain being of a less acute kind, by constant vomiting, and by the mucous surface being as intolerant of ingesta as in external gastritis the peritoneal membrane is intolerant of pressure. There is also sometimes frequent hiccough, and the patient complains of intense gastric acidity when anything is brought up from the stomach.

The diagnostic features between external and internal gastritis are, intolerance of pressure in the former, and a morbid sensibility of the mucous surface in the latter; in the former less, and in the latter more vomiting; in both, the pyrexia is equal. The causes of external gastritis are those which produce inflammation of the serous membranes, and the principal of these is cold. Those of endogastritis are more frequently errors in diet, such as eating ices when the body is overheated, or any food that may greatly excite the mucous membrane; but the most frequent causes are to be found in the swallowing of irritant poisons, such as arsenic, oxalic acid, and the like.

Treatment. The indication of cure is simply to subdue inflammation. In peritoneal gastritis, reliance is to be placed in one full bleeding, especially if the pulse be small, hard, and frequent; after which, the blood-letting should be local, by leeches applied to the *epigastric region*, and repeated at intervals as long as pain and tenderness may require them. After this symptom has been for the most part subdued, the vomiting may be combated by open blisters, and by calomel and opium, as in (*a*).

a. ℞ Hydrargyri chloridi gra. xii; pulveris opii gra. vj; confectionis rosæ q. s. Misce, et divide in pilulas xii, quarum sumatur una secundâ vel tertiâ quâque horâ, urgente dolore aut vomitu.

The diet should be farinaceous, and the trunk of the body in perfect rest upon the back, with the knees flexed towards the

pubes: the patient being able to resume the sitting posture is a most favourable sign.

In the treatment of endogastritis, there should be also one full bleeding from the arm; but, with regard to local bleeding, it will be best, in my judgment, to bleed the portal veins by the application of eight or ten leeches to the rectum, in the manner above recommended, to which the reader is referred. I have recommended one full bleeding only in this disease, because I have observed repeated *full* bleedings rapidly to produce exhaustion and death.

In the treatment of endogastritis, the less the mucous coat of the stomach, whilst the inflammation is high, is disturbed by food, the better; and even when the stomach is in a fit state to bear it, the most bland aliment is to be administered, such as barley-water, arrow-root, gruel, or sago. The best beverage will be soda-water, with a small proportion of milk or whey. Calomel and opium, as in (*a*), together with an open blister to the epigastrium, will be highly beneficial in this case also. In one well marked case of peritoneal gastritis that came under my care, the symptoms rapidly yielded to the frequent application of leeches and the internal adhibition of calomel and opium. When gastritis is caused by an irritant poison, the case is to be treated primarily according to the nature of the poison swallowed, and afterwards by such means as shall best subdue the inflammation produced, and which have been already recommended.

X.—Cancerous Condition of the Stomach.

The stomach, as well as many other parts of the alimentary canal, is liable to the ravages of this terrible disease. The parts of the viscus most subject to it are its orifices of ingress and egress: the later is most frequently attacked. The cardiac orifice is also occasionally affected by it, but far less frequently: indeed, cardiac cancer is of rare occurrence. When it does occur, it is more rapid in its progress than the pyloric, because the food, from the extreme intolerance of the œsophageal membrane, is rejected before it reaches the stomach for the purposes of nutrition.

The principal symptoms of gastric cancer are constant severe pain in the epigastric region, of a burning character; intolerance of food, which is rejected soon after it has reached the stomach; independently of food, there is frequent vomiting of mucus also, streaked with blood, and containing shreds of morbid tissue; atrophy and extreme emaciation; the eyes are remarkably bright, and their conjunctival membrane bloodless and transparent. But, instead of detailing the symptoms of the disease, I will at once proceed to describe two cases that came under my care in the Royal South Hants Infirmary, one of cardiac, and one of pyloric cancer, in which the symptoms of both will be respectively manifested.

Case xvi. *Cardiac Cancer.* The notes of this case were kindly taken for me by Dr. Lake in 1852, whilst he was resident surgeon of the institution.

Michael Lemen, aged 42, single, a native of Ireland, had worked for the last few years as coal porter in the Southampton docks, and always considered himself healthy till three months ago, before he came under my care. Since that time, he had been constantly troubled with vomiting and purging, and a pain in the stomach. During this time, he had become rapidly and *greatly* emaciated. He was admitted into the South Hants Infirmary, June 21st, 1852. The pain was referred to the epigastrium and *left* hypochondriac region. The vomiting and purging were of a dark grumous-looking matter. The body was very much emaciated. The eyes were prominent; and the conjunctival membranes were bloodless, and white as porcelain. The abdomen was greatly retracted, and the anterior surface of the spinal column could be easily felt through the abdominal parietes; but no tumour could be felt. The treatment consisted first of chalk, and laudanum, and bismuth; and then calomel and opium were tried: but, though by these means the purging was lessened, the vomiting continued. At length the hydrocyanic acid relieved it, and for ten days he seemed better; but then the vomiting and purging returned, and continued till his death. The vomiting took place always immediately after anything was swallowed, and it hardly appeared to reach the stomach before it was up again. For the last few days, he had slight cough. He died gradually August 29th, 1852, ten weeks after his admission, and rather more than five months from the commencement of the disease.

On examining the abdomen after death, the cardiac end of the stomach was found drawn high up under the ribs. A soft cancer occupied that end of the stomach projecting into the œsophagus. The stomach was adherent to the diaphragm, as was also the left lung, which was much inflamed and congested.

Case xvii. *Pyloric Cancer.* Anne F., aged 34, the wife of a traveller, became ill in April 1849, with pain in the epigastric region and sickness, which always took place after eating, and continued till the stomach was emptied by vomiting. She was costive, and sometimes for a fortnight she had no stool. The pain was of an aching and burning character; and, during the night, half a pint of clear watery fluid, having a bitter taste, would come off the stomach. She had not menstruated since the commencement of her illness. On June 17th, she was admitted into the Royal South Hants Infirmary. She was greatly emaciated; her skin was rough and of a dark colour; the abdomen was retracted and concave; and, in the locality of the pylorus, a small hard tumour could be felt, very tender under pressure, showing that it consisted of a scirrhous state of the pyloric orifice. It was at once evident that nothing beyond palliation could be effected in the way of treatment. She was ordered half a grain of the oxide of silver three times a day, in the form of a pill, with an occasional dose of rhubarb, and a fluid diet. This allayed the morbid sensibility of the stomach; the vomiting ceased; and the pain returned only when the bowels were confined. Notwithstanding this, she emaciated rapidly, and died, a perfect skeleton, on August 11th.

The body was examined the following day. The large curvature of the stomach was thickened, and the pylorus scirrhous and ulcerated; its orifice was so filled up as only to permit the size of a goosequill to pass through it.

In studying attentively these two cases, we are at once enabled to form an accurate diagnosis as to which of the gastric orifices is involved in the disease. If there be vomiting immediately after the deglutition of food, showing great intolerance of the œsophageal mucous membrane; if the pain be referred to the *left* hypochondriac region, a little below the ensiform cartilage; if deep pressure near the scrobiculus cordis produce pain and vomiting; if there be cough, shortness of breathing, and *rapid emaciation*,—the disease is cardiac cancer.

If the pain and vomiting do not take place till some little time after food has been swallowed; if the pain is referred to the lower part of the epigastric region, about midway between the inferior margin of the ribs on the right side of the thorax and the umbilicus; if a hard tumour be found at this spot by deep manipulation; if the manipulation produce great pain and a tendency to vomiting,—the tumour is the pylorus, and the disease is pyloric cancer, especially if there be great atrophy and emaciation.

With regard to the treatment of this disease, alleviation by opiates is the only benefit that can be effected; and oftentimes even this is impracticable.

THE METEOROLOGY OF 1858.

By J. A. Hingeston, Esq., M.R.C.S., L.S.A., L.M., (formerly Assistant-Surgeon to the Royal Maternity Charity, London), Brighton.

The year 1858 was a remarkable one both in a meteorological and sanitary point of view. There was an eclipse of the sun and moon in the spring, and a brilliant comet in the autumn; the mortality of the year was above, and the marriages and births were below the average. Indeed, during the last two weeks of November, the deaths were in excess of the births, and the natural increase of the population, which has been constantly progressive for so many years past, was, during this short interval, suddenly reduced below its steady and customary ratio. The natural increase of the population for the United Kingdom in 1858, was not more than six hundred and forty-two daily (*Quarterly Return*, 40, December 1858, page 2), whereas it had been throughout the preceding year 1857 as high as one thousand and twenty-one a day (*Quarterly Report*, 38, July 1858, page 2). The last three months of the year 1858 were particularly unhealthy; and the Registrar-General declares (*Quarterly Return*, 40, page 1), "that it has never before happened that so many deaths were registered in any autumn quarter, as in this last.") The mean mortality for 1857 was less than twenty-two in a thousand (*Annual Summary of* 1857, page 4), but the mean mortality of 1858 was twenty-three in a thousand (*Quarterly Return*, 40, December 1858, page 5). The year 1858 may, therefore, be regarded as a very unhealthy one.

The year began at the usual temperature of the month of January, the first and third weeks of which were as much as from three to four degrees below the average of the season.

February was cold nearly throughout. Snow fell on the 2nd, and lay upon the ground; and it continued to fall occasionally till the end of the month. On the night of the 26th, there was a partial eclipse of the moon, and the thermometer sank as low as 23° Fah.; the frost was severe, and the ice two inches thick. March was still colder than February, and the temperature of the first fortnight was as much as 8° Fah. below the average. Snow fell, and lay upon the ground, from the 1st to the 6th of the month. The frost then gave way to a partial thaw, with hail, rain, and sleet, followed by a heavy snow storm; and the ground was again white from the 11th to the 13th. This hard weather again ended in hail, rain, and sleet, and, finally, in a complete thaw. On the 15th, there was an almost total eclipse of the sun at 1.10 o'clock, p.m., of which I published a scientific account in the British Medical Journal, lxviii, *New Series*, April 17th, page 308. Previous to the eclipse, the electricity had been positive, and the weather cold, but subsequently it became negative, and the air warm, the temperature averaging about 3° in excess. The mean reading of the barometer throughout the first three months of the year was nearly half an inch in excess; and for the first fortnight after the eclipse, it stood above thirty inches, and, on the 22nd, rose as high as 30.422 inches. April and May were both of them cold, perhaps about 1° lower than the average; but June was hot throughout, and was said to be hotter than any month of June since 1771, except the June of 1846. The barometer stood unusually high, being scarcely less than thirty inches all the month. The weather was bright and pleasant. July was cold, and it was in the middle of the month about 5° in defect. August was fine, and September warm, and at one time 4° in excess. The air was remarkably dry, clear, and luminous. The harvest began early. Wheat was cut on July 17th, or nearly three weeks earlier than usual, although the yield of corn was not so very great. There were severe thunder-storms in July and August; and the aurora was seen at Liverpool on July the 16th.

A singularly brilliant comet appeared in the N.W. in September and October. Its right ascension, September 28th, was 12h. 46m. 30s.; its declination 32° 19' 9" N.; and its time of setting in London, 9.53 p.m. On October 10th, when it was nearest the earth, its right ascension was 15h. 7m. 5s.; its declination 4° 38' 2" N.; and its time of setting in London 8.15 p.m. In a letter to the editor of the *Times*, dated September 28th, Mr. Hinds calculates its distance from the earth, on October 10th, at 51,000,000 of miles, and the apparent length of its tail about 12°, corresponding to a real length of 16,000,000 of miles. Arcturus was visible through it. In the transparent atmosphere of the continent, I had an opportunity, not often met with, of enjoying the splendid sight of this inexplicable meteor or eccentric planet, as I travelled from Montpellier to Dijon, and from thence to Fontainebleau, Paris, Dieppe, and home.

October was fine. It began with the aurora, and strong gales. A few cold, fresh days excepted, it was nearly 2° above the average. November, on the contrary, was extremely cold; the mean temperature of the 23rd and 24th was reported at Greenwich to have been lower than any two consecutive days in November during the last forty-five years. On the 24th, the thermometer sank 12° below the freezing point of water. The mean temperature of the month was not more than 39·6° Fah. In Paris the thermometer was 10° lower than in England, and in Austria it was reported 10° lower than that. There were heavy falls of snow in the north of Great Britain, and also in Belgium and France. At Lyons the streets were nearly blocked up with it. The same weather occurred in Italy. In England, thick mists prevailed throughout the quarter, and November was particularly remarkable for several very dark fogs. On the 15th of this month, there was a severe storm of wind that did great damage to life and property, both by sea and land; and, then, the weather suddenly became warmer, and was nearly 6° in excess of the season. December was likewise warm; there was thunder on the 18th; and the year closed at a temperature of 1° warmer than usual. There was a great deal of illness everywhere; and the death-rate was higher than in any autumn quarter upon record. It is very remarkable, that, during this sickly period, from November 14th to December the 31st, little or no terrestrial electricity was exhibited by the electrometer, and that what little showed itself was, with the exception of December the 22nd, uniformly weak and negative. At the same time, the humidity of the air was almost *plus*, as it was denoted by the figures 81 or 92, complete saturation being 100. No state of atmosphere could be more adverse to health and life than this.

The wind blew from the S.W. for about two hundred days; all the rest of the year, it was from the N.E., with some few exceptions from the N.W., and still fewer from the S.E. The mean horizontal force of the wind was about five hundred and fifteen miles a week, according to Whewell's anemometer, Greenwich; which is considerably stronger than in the preceding year, 1857, which averaged scarcely more than two hundred miles a week. The first week in December was the calmest of the year; and the third week in December, and the second in May, the most blustering. The vernal equinox was calm; the autumnal, tempestuous.

The amount of rainfall in the twelvemonth did not exceed eighteen inches, the annual amount being about twenty-four or twenty-seven inches. It was a dry summer; and, in many parts of the country, the wells were exhausted, and the pasturage burnt up. It was a good season for wall-fruit, and the orchards were very productive. I am old enough to remember the comet of 1811, and can distinctly recollect the parched state of the ground in the autumn of that year. This summer I was in the south of France, and can bear testimony to the universal satisfaction expressed at the excellence and abundance of what is called a *comet-vintage*.

While travelling, I noted the weather; and, in comparing notes on my return, I found that the wet and the fine days on the continent corresponded almost exactly with those in England. Thus, the 24th of July, which was wet in London, was the same in Paris. The 28th was wet at Poitiers, and also in London. On Sunday, August 5th—a very hot day at Angoulême—the thermometer stood at 100° Fah. in the sun; at Greenwich, and at Bordeaux, it was 80° in the shade. Between August 8th and 16th, I was at St. Nicolas, near Sarlat, in the Dordogne, while the weather, which was so hot here, was the same there; and on the 14th, as I was looking at a sketch just drawn from Nature, "a great and unusual darkness", to quote the very words of the Greenwich reporter in the Registrar-General's *Weekly Returns*, under that date, p. 264, "prevailed about 4 P.M.; the wind changed from N. to W.; rain fell heavily; lightning was seen; and thunder frequently heard." On the 18th of August, it was rainy at London, as well as at Bayonne; and, while we were exposed to the *mistral*, that "scourge of the south", at Nimes, a strong gale was blowing from the E. at Greenwich at the same time—viz., September 23rd. The apophthegm, "Cœlum, non animum, mutant qui trans mare currunt" (Hor., lib. i, epis. xi, 27), is, as far as my experience goes, just the reverse of truth.

Shortly after my visit to Bayonne, that fortress was shaken in the autumn by an earthquake, which extended as far as Biarritz on the coast, and St. Jean de Luz at the foot of the Pyrenees. In October, there was a severe shock of an earthquake at Lisbon and its neighbourhood, the most violent since the great one of 1775. Five persons lost their lives, and many were injured by it. At the close of the year, a third was reported from Venice and the coasts of the Adriatic. Most likely shocks are always happening, although not always reported. Strabo, who, in his day, considered Vesuvius as an extinct volcano, and describes the vines and flourishing verdure that reached almost to its top (Lib. v, c. iv, § 8), gives a long catalogue of the volcanic eruptions that had repeatedly altered the face of Nature, in the Archipelago, in the old times before him (Lib. i, c. iii, § 16, *et seq.*); and the venerable Humboldt has recently treated of the same subject in a more masterly and scientific manner, though certainly not in a more emphatic and pleasing style, than that of the celebrated Greek naturalist and geographer, eighteen centuries before him. (*Cosmos*, vol. i, p. 199, *et seq.*; vol v, *passim.*)

The inner life of the earth affects the health, happiness, and prosperity of mankind, as intimately as the external agencies of light, heat, and electricity, as well as the more dazzling meteoric phenomena, such as lightning, solar or lunar eclipses, volcanic fires, mephitic emanations, and those enigmas of astronomy, comets and candescent aërolites, are supposed to do. Their noxious influence on both mind and body is ancient and proverbial. The past year is a case in point. They are electro-galvanic operations, increasing or intercepting the solar beam, the degrees of heat, and the several combinations of the air we breathe, on so extensive a scale that they cannot fail in modifying the highly sensitive nervous structure of the human frame, whose delicate machinery is set in motion by a current of chemico-vital dynamics, that excite, suspend, or abolish animal existence, at a touch as fine and decisive as it is permanent and gigantic.

HIP-JOINT DISEASE: ITS SYMPTOMATOLOGY AND DIAGNOSIS.

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The following essay is partly the result of a perusal of a variety of works on the subject of which it treats, partly of observations made at the bedside. In it I purpose giving a *resumé* of the pathological phenomena presented to us during life, in one of the most important joints of the human frame—important, not only for its magnitude and functions, but also for the variety of diseases to which it is subject.

By far the most common disease of the hip is of a scrofulous nature. It has been known under a variety of denominations—in this country, most commonly as the morbus coxæ, a name wrong in itself, implying tacitly, as it does, that that is the only disease to which the hip-joint is liable, which is far from being the case. The disease in question was not unknown to the ancients, amongst whom may be mentioned more especially Hippocrates, Galen, and the Arabian writers.

The first scientific memoir on the subject, however, was that of Petit, in a paper, entitled *Observations Anatomiques et Pathologiques sur les Chûtes qui causent une Luxation dont les auteurs n'ont point écrit*, read before the Academiè Royale des Sciences, on February 25th, 1772. Here we find what appears to me to be a very meagre and unsatisfactory account of the disease. Overlooking the constitutional nature of the affection, Petit thought the head of the femur was displaced gradually from its socket by a hypersecretion of fluid into the joint, consequent upon some severe contusion that this had sustained, and that after a certain lapse of time, the bone was dislocated upwards by the action of the muscles, so that the limb was shortened. It is surprising that he should have overlooked the preceding elongation, although he, evidently feeling a difficulty on this point, explained it away, by the peculiar conformation of the osseous structures entering into the composition of the joint.

The first really good description of the disease was that given by Boyer in his *Leçons*, published in 1803. In an article on the spontaneous or consecutive luxations of the femur, we find a very excellent account of the subject illustrated by cases and autopsies. He recognised the elongation of the limb prior to its shortening; regarding it, however, as *real*, and depending on an engorgement of the so-called synovial gland and cartilages of the joint. He recognised the sympathetic pain in the knee, the final shortening of the limb, which he viewed as exclusively due to a consecutive luxation, a fact, we now know, of nothing like that universal occurrence that Boyer would have led us to believe, and lastly, what was very important, he recognises the *constitutional nature of the affection*.

A few years after an exceedingly good account of the disease in question appeared in England in a work by Mr. Edward Ford, entitled, *Observations on the Disease of the Hip-joint*; where he has given us a very faithful description of some of the principal phenomena of the morbus coxæ. And since his time, the subject has been variously illustrated by Brodie, Coulson, and many of the French writers.

No age is said to be exempt from this disease, but at the same time, it has a remarkable tendency to fix itself upon young persons. The youngest age I have observed it in is 2 years, and the oldest 32. Albers mentions three cases of congenital morbus coxæ; Morgagni a case in an infant a few months old; Coulson, a case in a child a month old. On the other hand, cases are recorded by authors at ages of from 30 to 50; and Coulson states that he has seen many cases in persons advanced in years.

In all the cases that have come under my notice I have not been able to trace any hereditary predisposition to tuberculosis, although it must be acknowledged that it is often a matter of considerable difficulty to obtain sufficiently precise data on this point; whilst, on the other hand, cases are recorded of the affection occurring in two or more members of the same family. But a marked predisposition may be observed in the patient's own constitution, which in most cases is highly scrofulous, or, at any rate, of a delicate susceptible nature. Rheumatism is sometimes the precursor of the disease. I have seen a well marked instance of this. It was in a girl named Sheen, who was admitted into University College Hospital, under Dr. Garrod, some years ago, with an attack of acute rheumatism in the right shoulder, wrist, and hip; subsequently the left shoulder became affected; and, lastly, the right thigh and knee became painful on movements of the limb. All the joints got ultimately cured, though very slowly, excepting those of the right lower extremity; this was subsequently found to present the signs of genuine morbus coxæ of a very acute form. She was then transferred to the surgical wards. I then found an apparent shortening of the limb to the extent of two inches, a real one, of about three quarters of an inch, a certain amount of pain at the hip, on pressing the femur firmly upwards; most intense pain on rotating the limb. She was also much troubled with painful startings. Here, then, was a case of indubitable acute rheumatism merging into a case of indubitable morbus coxæ. Coulson records a case of its following gonorrhœa, and mentions, as does Boyer, that it may be a sequel of the exanthemata.

It is curious to observe how, in the majority of cases, patients date the first commencement of the affection of the joint from some trifling local injury, generally from a fall on the hip, sometimes from some over-exertion of the joint in running, etc. This fact is not only curious, but of the highest practical importance, warning us to treat any injury of the hip that may come before us in a decided and cautious manner, especially when it occurs to young subjects, lest the at first slight local lesion develope itself into a disease of the joint, always difficult to treat, often of a most intractable, and, in some cases, of a fatal nature.

It is in the minority of cases only that the disease commences spontaneously without any previous exciting cause. The first symptoms observed are often apparently of a trivial character, although generally, if the exciting cause has been an injury, the symptoms may for the first two or three days be of a tolerably acute nature. The patient may in the first instance complain only of slight and transient pains about the hip and knee, which become aggravated by any extra exertion on his part; whilst, at the same time, he has habitually a slight limp in his walk, and has a tendency to keep the knee stiff. Very often these symptoms are accompanied by a certain amount of listlessness in the patient's manner, inaptitude for much exertion, and other slight impairments of his general health. These symptoms may go on increasing gradually till the patient is rendered totally incapable of getting about, or this crisis may be arrived at in a sudden and acute manner by some additional slight injury to, or over exertion of the joint.

Supposing, now, we are called to a patient at this stage of the disease (adverted to by Coulson as the second stage), what are the chief local phenomena observed? The first thing that strikes the attention of even the most superficial observer, looking at the patient, as he lies in bed, is a remarkable difference in the length of the two lower extremities. In the majority of cases, the diseased limb appears to be longer than the sound one, as evinced by the relative positions of the two knees and inner ankles. I say "appears," because a more careful examination shows this difference in length of the two limbs to be nothing but an *apparent* difference; for, on directing our attention to the relative positions of the two iliac spines, it becomes obvious, that this apparent difference in length is dependant upon the tilting downwards of the pelvis towards the diseased side, and the explanation of this distorted position of the pelvis is readily found by studying the posture which a patient spontaneously assumes on requesting him to stand erect, and this posture is *per se* a very excellent indication, as to the nature of the affection, to the eye of a person who has seen many of these cases. The patient stands with the sound limb firmly extended, receiving obviously as it does by far the greater share of the weight of the body; whilst, on the other hand, the thigh and leg of the diseased limb are in a state of semiflexion, the whole limb in advance of the other, the foot slightly everted, the heel raised from the ground, receiving but a small share of the weight of the body on the toes. This very remarkable contrast in the position of the two limbs is very faithfully delineated by Ford, in the first plate of his work on the hip-joint, already alluded to in an early part of my paper. And when we come to consider the pain which any pressure of the head of the thigh bone against the acetabulum causes the patient, the assumption of the peculiar posture just described becomes at once evident.

No symptom has given rise to more discussion as to its cause than this one. The above is the common explanation, and is that adopted by Sir C. Bell, Brodie, Coulson, Malgaigne, and Parise. But it has always struck me, that, although the general statement that the apparent alterations in length of the limb depend upon corresponding alterations of the level of the iliac spines is correct, still, that it will not account *fully* for all the

facts observed, and I see that M. Parise is of the same opinion. He very justly asks, how are these apparent deviations in length to be accounted for in patients who have kept their bed during the whole of their illness? In the case of a girl under my notice, she had an apparent shortening of two inches, notwithstanding she never once left her bed from the commencement of her attack up to the time I made this observation.

What is it again that causes patients to preserve obstinately such a distorted position in bed, as they are often seen to do, giving rise to a corresponding apparent difference in the length of the two limbs? How is it, too, that an apparent lengthening may ultimately be succeeded by an apparent shortening, a fact, rather the rule than the exception? M. Parise gives, to my ideas, an equally unsatisfactory account of it. I think the subject requires, and is worthy of further investigation. Coulson thinks that there is also a *real* lengthening at this stage of the disease, produced by the diseased limb's weight stretching the ligamentum teres, a fact more especially adverted to by Palletta. Mr. S. Cooper has, I think, very justly objected that Weber has shown the head of the femur will not leave the acetabulum unless the atmospheric pressure on it be in a state of equilibrium.

In three cases, however, of well marked diseased hip that came under my observation, I have met with an apparent shortening of the limb.

In the early stages of the disease, no real difference is discoverable in the length of the two limbs; but at a later period (in the third stage of the disease of Coulson,) the diseased limb undergoes a real and palpable shortening. And this shortening is dependent on some organic change in the structures entering into the composition of the joint.

It was formerly the prevalent idea that this always depended on some consecutive luxation of the head of the femur. Later observation has shewn these dislocations to be comparatively rare, and that the real shortening depends on carious absorption of the head and neck of the thigh-bone and deepening of the cotyloid cavity, the femur being drawn up by the muscles in proportion as these destructive changes take place. It occasionally, however, does happen, that the femur becomes dislocated in the last stages of the disease. The dislocation is generally on to the dorsum of the ilium, producing a shortening of the limb, nearly to the extent of four inches; and in very rare cases it has been known to be dislocated down into the foramen ovale, producing a corresponding elongation of the limb.

Another obvious phenomenon that the diseased limb presents, is the general wasting of the muscles consequent upon their disuse; and this muscular atrophy has acquired a special significance with reference to the large gluteal muscle, giving rise to a very characteristic appearance of the nates. These become flattened, and hang loose on the diseased side, and the contour of the lower border is very much less prominent and distinct than on the sound side, amounting in some instances nearly to an absolute obliteration, while at the same time it slopes more downwards. In the last stages of the disease, this flattening of the nates is succeeded by a preternatural fullness and tension; this is due to the inflammatory action induced by the formation of abscess in the joint.

The parts about the groin, on the contrary, are fuller than natural, obscuring in many instances in a marked degree the inguinal fold. These appearances depend probably on some inflammatory swelling about the tissues of the joint. It is also by no means uncommon to find the inguinal glands preternaturally engorged; rarely, however, the seat of pain.

I come now to speak of one of the most distressing symptoms of this serious affection of the joint. I mean the pain to which it gives rise; and if any person would wish to form a just estimate of the importance of an accurate knowledge of the symptomatology of the disease, he would only have to contemplate for one moment the acute sufferings and utter helplessness of a patient, in whom the malady has made any progress, rendering him so totally dependant, as it does, upon the assistance of those around him. The pain induced by the slightest movements of the joint, has been in most of the cases that I have witnessed, of so intense a description, as to force the patient to absolutely shriek out, and bring tears into his eyes. And this, not only in children, but even in persons who have arrived at years of discretion.

As regards its seat:—At the hip it is always present, and in the majority of instances also in the knee: the pain at this latter part being often more severe, and the most permanent feature of the patient's sufferings, although this joint is unimplicated in any organic disease; and at the first periods of the commencement of the disease, you will commonly find this pain at the knee the only thing the patient complains of; and oftentimes have careless practitioners thus been led to treat the knee affection as an independent disease, whereas it is to be regarded merely as a symptom, the true organic disease being in the hip. The *rationale* of this symptom has been the subject of much disputation. The best known and most widely propagated explanation of the fact is that of Sir C. Bell, founded on the anatomical disposition of the obturator nerve, which supplies the hip-joint and partly the knee—the inflammatory pains being referred to its centrifugal extremities. An objection to this explanation is, that the same phenomena are not observed in white-swellings of the elbow-joint, where one might reasonably in the same way expect a sympathetic pain in the wrist depending upon an implication of the ulnar nerve. Another solution of the problem has been sought in the supposition, that inflammatory action of the thigh bone from its upper end, was propagated downwards to its lower end. In this case, however, we should expect to find intermediate points of the femur the seats of pain; and though the patient sometimes complains of pain in the thigh, it is often limited strictly to the hip and knee; besides which, on this supposition, we should expect the knee-joint to offer some palpable physical indications of disease, which it does not. The same objections may be raised against Mr. Coulson's supposition, that it depends on an inflammatory implication of the rectus femoris, which is closely connected with both hip- and knee-joints.

Another very common symptom of the disease is what the patients call "jumpings" of the leg. This consists in violent spasmodic action of the flexor muscles of the thigh, and occurs when the patient is dropping off to sleep, causing severe pain at the two joints. It often, however, awakens the patient when he is asleep, disturbing and breaking his night's rest to a distressing and harassing degree. In one remarkable case, that of a girl, named Rebecca Jones, this spasmodic action of the muscles was constant day and night, and involved not only the muscles of the thigh, but also those of the leg. I cannot do better, perhaps, than transcribe my notes of this condition. "The whole of the thigh is in one constant state of quivering, both at its outer and inner aspects; and the spasm of the quadriceps extensor muscle is such as to raise and depress the patella in a rapid succession of jerks, causing a distinct tumour to appear and disappear alternately in this position, the hand placed on the knee-cap thus experiencing a rapid series of succussions, and in the same way the toes are the subject of a continual agitating tremor." A case of the same description is mentioned by Sir B. Brodie, in his work on the joints. In this instance, however, the spasms were limited to the muscles of the thigh; and appear from his account to have required some slight motion of the limb for their production. In this case, there was found, after death, a deep-seated abscess among the muscles of the thigh below the hip-joint beneath the anterior crural nerve, and bound down by the femoral fasciæ. During life, an abscess presented itself on the fore part of the thigh, after the appearance of which the spasmodic affection gradually subsided. From these facts, Brodie concludes that the peculiar symptoms arose from the deep-seated abscess pent up among unyielding parts, thus pressing on and irritating the anterior crural and obturator nerves, and that the abatement of them arose from the removal of the pressure on the nerves by the abscess making its way externally. I have observed something like this spasm of the muscles in another case of joint affection of a different nature, in a young man, who was some years back in University College Hospital. In him, on flexing the toes of his left foot, they at once became the subject of a constant tremor, which he could not restrain; this phenomenon disappeared during his stay in the hospital.

In the last stages of the disease, matter forming within the joint comes to the surface either on the nates, the groin, or upper and outer part of the thigh. Cases have been known in which it has passed by the pelvis into the rectum, and voided by this channel. I have seen one such case myself. Small portions of bone are often found in the discharge; and in two cases mentioned by Hoffman, and one by Mr. Chalk, nearly the whole of the head of the femur came away entire in this manner. In some cases, the patient sinks in a hectic state, induced by the profuse suppuration. In other more fortunate cases, he escapes with an anchylosed joint.

I now come to speak of a very important point; viz., of the diagnosis of true morbus coxæ, from other affections to which the hip-joint is liable. Elizabeth C., aged 54, was admitted

seven years ago into University College Hospital, for an affection of the right hip-joint. She first began to feel pain in walking in the right hip-joint three months before admission; and for the last two months she had been absolutely lame; but had always slept well. There was a real shortening of the limb of three-quarters of an inch; firm pressure from the foot did not seem to cause much pain; she experienced pain at the hip from flexing the thigh, and likewise slight pain from flexing the thigh of the unaffected limb.

This was a case of rheumatic affection of the joint, and not one of morbus coxæ; and for these reasons:—1. The age of the patient. 2. There was no evidence of pain on pressing the articular surfaces of the affected joint together, which would certainly have been present with a real shortening of three-quarters of an inch. 3. The absence of any special pain in the knee. 4. The fact that she slept well during her illness, not having had any startings of the limb. 5. The pain evinced on flexing the left limb.

I shall now, in the same way, illustrate the diagnosis from another affection of the joint, by the recital of a case.

Jane F., aged 24, was admitted into University College Hospital, on June 1st, 1853. There was no evidence of rheumatism, but some of phthisis, in her family. She menstruated at about the age of 15 or 16, but only once or twice in the year, and that scantily. At the age of 21, she began to be troubled with leucorrhœa between the intervals of the catamenia, which now became regular. Her present affection dated from two years back. There was an apparent shortening of an inch of the left limb, dependent upon a distorted position of the pelvis. There was no real difference in the length of the two limbs; firm pressure upwards from the heel caused slight pain at the hip; rotation, especially inwards, caused more pain; succussion caused acute pain in the hip and spine. Succussion of the spinal region, especially of the right vertebral groove of the lower half of the spine, caused acute pain. Some pain was produced on firmly pinching the soft parts about the spine. The pain produced in all these cases appeared to be of a very transient though acute nature; and I cannot better express what the nature of the patient's feelings seemed to be, than by saying the pain made her wince. Ever since a child, this patient had had difficulty in passing her urine; and during her stay in the hospital, it became a question at one time whether the catheter should not be used. Her bowels also had habitually been costive; so much so, that even on one occasion two doses of a drop of croton oil failed to produce any effect. She was much troubled with painful startings of the limb. This was a case of so called hysterical affection of the joint.

The diagnosis depended on the following points:—1. The general derangement of the urinary, generative and alimentary functions, above adverted to. 2. The absence of any real difference of length in the limbs. 3. The presence of the spinal irritation. 4. The fact that the disease had lasted for two years, without producing any deviation in the length of the limb. And lastly, the peculiar character of the pain induced by manipulation.

This case disproves a circumstance mentioned by Brodie, who states that in these cases, whatever the pain may be during the day, it does not awaken them during their sleep. A curious fact is mentioned by this last author, in reference to these cases. He states, that often in the morning the limb will become cold, pale, and shrunk; but that towards evening, the surface of the skin becomes hot, red, and shining, and that these alterations are as regular as the paroxysms of an ague, and like these are much benefited by the administration of quinine.

Children at the time of dentition are subject to a disease of the hip, closely simulating morbus coxæ. In these cases, the child in attempting to walk, drags the affected limb after him, and in standing, assumes much the position I have adverted to as characteristic of true scrofulous disease of the hip; wasting of the whole limb and nates, and slight lengthening, are observed. The diagnosis of this disease depends mainly on the absence of any pain on manipulating the joint, and on the period of life at which it occurs.

I trust that I have now given as comprehensive a view of the subject as my experience has allowed me, with a view of establishing the diagnosis from other affections of the joint to which I have adverted; and I cannot too strongly impress the necessity of forming a correct opinion of the nature of any given affection of this joint, than by stating that the *treatment* of these cases invariably depends on this point. What would one say, for instance, to the application of splints, issues, moxas, and the like, to a patient labouring under mere neuralgia of the joint; which, as Brodie in his work on the urinary organs, remarks is an error that is as discreditable to the practitioner as it is mischievous to society. And further, I have seen several other cases where an accurate knowledge of the symptomatology of these affections was of very material aid in coming to a conclusion as to the nature of the one under consideration. Mr. Abernethy states that pains in the hip and knee, and even wasting of the limb, will occur from mere derangements of the digestive organs; as Sir C. Bell says, they will from those of the urinary apparatus: and it is only by correct and precise information on these matters that a surgeon is enabled to do his patient good, and himself credit.

Reviews and Notices.

A Treatise on the Human Skeleton (including the Joints.) By George Murray Humphry, M.B.Cantab., F.R.C.S., Surgeon to Addenbrooke's Hospital; Lecturer on Surgery and Anatomy in the Cambridge University Medical School. With numerous plates. Pp. 620. Cambridge and London: Macmillan and Co. 1859.

We almost feel that an apology is due to the members of the British Medical Association for our tardiness; but it may be received as an additional testimony in favour of the work before us, that we have felt it impossible to do justice to it without making a more careful examination, than is sufficient for the vast majority of the books that are issued from the medical press in the present day.

It is with more than ordinary pleasure that we now draw the attention of our associates to this work. Every page of it is replete with information, which is oftentimes original in matter, and always new in the manner in which the facts are stated. We speak from experience when we say that the work will fully bear the test given in Todd's *Student's Guide*—"The book that is worth reading once will bear reading twice."

We welcome this work, not merely on account of its intrinsic excellence, but also because we perceive in it an attempt, which we hope and believe will be successful, to introduce into our schools a more philosophic and better mode of teaching human anatomy, than is at present usually adopted.

Since the days of John Bell, little or no real advance has been made in this branch of medical education. Many books, it is true, have appeared, containing somewhat more concise accounts and more beautiful representations of parts. They have the merit of putting the student more quickly in possession of the names of the processes, the points of attachment of the muscles, etc.; but, as regards attempts to convey a more scientific knowledge of anatomy, the writers and teachers of the present generation are, we fear, on the whole rather behind their predecessors. Minute anatomy seems to have engrossed the attention of the ablest teachers of modern times; and little progress has been made in descriptive anatomy.

Mr. Humphry has made a very successful effort to supply what was wanted, and has done much to advance the study of the human skeleton to its proper rank as a science. He is not content that the student should merely know the name and shape of a bone, a process, and a ligament; but he enters into the rationale of its form and construction. He tells us (page 485), *why* the leg is made so small just above the ankle, and points out certain disadvantages that result from it; *why* (page 482) the outer articular facet of the patella is larger than the inner, which, by the way, he informs us, is a peculiarity of the human patella; *why* (page 414) the tendon of the biceps plays chiefly upon the *lesser* tubercle of the humerus; *why* (page 94) the fœtal brain and skull are so large; *why* (page 206) the inner table of the adult skull is denser than the outer; *why* it is thrown up into so many ridges, which project in a seemingly

awkward manner into the cavity, and *why* the tough processes of the dura mater are attached to these ridges.

We recommend this work, *first*, to all teachers of practical anatomy, who wish to teach their pupils to think, and would help them to remember the facts that they learn; *secondly*, to all students who desire to know something beyond the mere facts of anatomy; and, *thirdly*, to physicians and surgeons who have not lost all interest in the study of the human frame; who would like to renew their acquaintance with an old friend in a new dress, and who wish to cultivate the habit of comparing the facts of surgery with the facts of anatomy, and of enlivening and elucidating the one by the other.

The account of the structure and movements of the joints forms perhaps the most important part of the book, in consequence of the great pains which have evidently been bestowed upon it, and the many points in which it differs from the descriptions usually given. Mr. Humphry states (page 166) that rotation of the spine is not practicable in the loins, and that it is most free in the back; that the ligamentum teres of the hip cannot be made tense in the extended position, and cannot, therefore, as Weber and others have supposed, be of service when we stand upright. We find also a description of a *short* internal ligament of the temporo-maxillary joint, "which seems to have escaped the observation of anatomists, though it is a well defined structure."

We feel sure that every earnest teacher of anatomy will, before the commencement of next session, make himself acquainted with the many new facts, of which the foregoing are examples; and we hope that lecturers will take the trouble to test the accuracy of the descriptions which are given. Following in the steps of Mr. Humphry, they will quickly find how to make the usually dry details of their course intensely interesting.

We advise medical students to resort to this volume, with the firm conviction that, in spite of the great amount of the information that it contains, it will be found to lighten and not to add to their labours. We fully sympathise with this class of our readers, and view, with as much distrust as themselves, every addition to the almost innumerable subjects which are now required of them. But it is because we believe that the present work supplies that which is wanted in other elementary departments of his studies, that we do not hesitate to introduce him to one who will teach him the anatomy of the bones as part of one comprehensive science of medicine, and not as an isolated subject—a drudgery to which every one must submit.

Mr. Humphry makes the reader feel that he has the subject before him. His style of teaching is peculiarly happy. He takes advantage of the knowledge with which even the unscientific reader is familiar; and, proceeding from things known to things unknown—the true and philosophic way of teaching—every additional fact serves to impress on the mind that which has been previously acquired, and it is made the stepping-stone to the next discovery. The range of motion of a joint being matter of every day experience, the shape of the articulating surfaces is accurately noted and compared with it; and the length, strength, and position of the ligaments, become stages in a process of inductive reasoning. In this way, the student is encouraged, his scattered thoughts are collected, and even the most minute differences and relations of the parts are remembered with comparative ease. We need hardly say that our remarks are not addressed to those who care only "how to pass", but we have in view first class students who wish to have an intelligent knowledge of their profession. To the men who rely on what Sir James Clark justly calls "the demoralising system of cramming", we would only say, beware how you present yourself before an examiner, without having one or two of Humphry's new dodges stowed in "your literary lumber-room".

Of the pleasant way in which the author lightens the subject in hand, we select the paragraph on the adaptation of the skull to the office of protecting the brain.

"It is the office of the skull to protect the important nervous centres contained within it; and when we reflect how large a mass the brain is, and that its delicate vascular structure renders it peculiarly liable to suffer from contusion and jars, we perceive that it must be no easy matter to secure it from injury during the rapid movements of the body, and the collisions to which we are often exposed. Yet so admirably suited to this purpose are its coverings, and so nicely adapted to one another are the brain and the skull, that we very seldom find any serious mischief occurring to the brain, except it be from a fall upon the head, or a blow, sufficiently severe to fracture the skull. If, therefore, in any case of injury to the head, we can assure ourselves that the skull remains entire, we may be pretty certain that the brain is not lacerated or shaken beyond recovery. The patient may be stunned; but he will probably recover his consciousness after a time, and eventually do well. A few instances are on record in which concussion has proved fatal without fracture; they are, however, very few, so few that they may be regarded as rare exceptions to the rule. On the other hand, if the symptoms of cerebral lesion be so severe as to preclude the hope of recovery, that alone is tolerably conclusive evidence of fracture of the skull. In short, the skull is constituted in such a manner that, so long as it retains its integrity, it is able to protect its contents from serious lesion; and nothing short of a blow, which breaks it, will succeed in contusing or tearing the brain." (P. 200.)

We would willingly give a more elaborate commendation of the admirable plates, and of the practical value of the work, but we must now conclude by saying, briefly but in all sincerity, that it seldom falls to our lot to review a volume so instructive, and that sooner or later every member of the medical profession should acquaint himself with 'Humphry on the Skeleton.'

LETTERS AND COMMUNICATIONS.

Letters or communications for the Journal should be addressed to Dr. Wynter, Coleherne Court, Old Brompton, S.W.

Letters regarding the business department of the Journal, and corrected proofs, should be sent to 37, Great Queen Street, Lincoln's Inn Fields, W.C.

British Medical Journal.

SATURDAY, MARCH 19th, 1859.

OUR ILLUSTRIOUS DEAD.

An order in Council for the removal of all coffins from the vaults under the church of St. Martin-in-the-Fields, has led to the discovery of the remains of the celebrated surgeon and physiologist, John Hunter. Mr. F. T. Buckland, of the 2nd Life Guards, son of the late distinguished geologist, and Mr. Quekett, curator of the museum of the College Museum, were kindly permitted by the authorities of the church to be present during the removal, with the object of discovering the coffin of Hunter. A coffin, containing the remains of a John Hunter, was speedily found, but this turned out not to be the illustrious dust these gentlemen were in search of; they were, indeed, guided to the exact spot in which the body was deposited, by the entry in the Parish Register, which was as follows:—

October 22nd, 1793.

Apoplexy.	M. John Hunter, Esq.	£6 10*s.* 2*d.*
Leicester Square.	No candles.	¼ past 4 o'clock.
V. N. 3.	Duty 3*d.*	

The entry, therefore, signified that he was buried in vault No. 3 (under the Church). "And this vault," says Mr. Buck-

land, "I found to be quite full of coffins, from the ground to the roof." On the afternoon of Tuesday, February 22nd, Mr. Buckland was rewarded by finding the coffin of John Hunter, underneath several others, and towards the back of the vault—being, in fact, almost one of the last to be removed. He describes it as being in excellent preservation, the cloth only upon it having decayed in places; the handsome brass plate as perfect as when originally engraved; the coat of arms uninjured; and the inscription clear and distinct. The latter runs as follows:—"John Hunter, Esq., died October 16, 1793, aged 64 years."

In a letter dated March 3rd, Mr. Belfour, the Secretary to the Royal College of Surgeons, writes to the *Times* that "the Council of the College, feeling it their duty to obtain for the remains of this illustrious man a resting place worthy of them, have asked permission of the Dean and Chapter to deposit them in Westminster Abbey, which has been most readily accorded, these authorities stating also that 'they shall be proud to be the guardians there of the ashes of so great a man.'"

The College has appointed the 28th instant for the re-interment of this most illustrious surgeon, and have intimated their intention to issue tickets, procurable at the College, until the 25th instant, to those medical men who would wish to see the grave close finally over the great surgeon. We rejoice to find the Council has at least more respect for Hunter's ashes than they had for his old chairs, which, including his favourite arm-chair, were sold for an old song, some years since, to the first bidder. We think, however, that they might have made more of the occasion. The profession might have been called upon to follow the remains of this great medical philosopher from his first to his last resting-place—from St. Martin's-in-the-Fields to the Old Abbey whose very foundations are rooted among illustrious dust, and which, amid its silent city of long-departed poets, painters, statesmen, divines, and philosophers, contains no medical inscription, at least, comparable with the *Hic Jacet Johannes Hunter*, which, ere long, will direct the footsteps of the living to his grave. It would be well, we think, now and then to draw public attention to the departed great ones of our profession, who have left, like John Hunter, such deep "impressions on the sands of time"; and a solemn procession of the followers of our art, bearing, amid the ceaseless stream of life that flows along Charing Cross, the remains of one who, "being dead, yet liveth" in the memory of all civilised nations, would, we think, be no ungraceful or impolitic act. The statue which is to be erected may come afterwards, but we want some warmer living testimony of our appreciation of the genius which filled the College of Surgeons with priceless intellectual treasures.

And we may ask, Should not Harvey, as well as Hunter, sleep with kings and princes beneath the solemn vault of St. Peter's? If the latter was the typical surgeon, the former was the typical physician. The remains of the great Harvey lie entirely neglected at Hempstead in Essex, in the family vault, the brickwork of which is so dilapidated that any thief may enter and carry off the leaden coffin, philosopher, and all; for a friend informs us it is so small and light that a strong man can easily lift it in his arms. It surely is a reproach to us all, that so little public honour has been done to the remains of the discoverer of the circulation of the blood; and we trust the College of Physicians will not be behind the College of Surgeons in rescuing from an obscure grave the ashes of their illustrious Fellow, which should lie side by side with those of Hunter.

POOR-LAW MEDICAL REFORM.

Within the last week, we have received, in the form of a pamphlet issued by Mr. Griffin, an account of the proceedings of a deputation of Mr. Griffin and other Poor-Law Medical Officers, who waited on Mr. Sotheron-Estcourt, the then President of the Poor-Law Board, on the 24th of last month. In another page, we give a copy of the proposals made by Mr. Griffin; and, believing that the information, though late, will be of interest, we give *verbatim* the reply of Mr. Sotheron-Estcourt:—

"If it may be said that the medical officer is at the mercy of the guardians because it is in their power to diminish the number of paupers in January and July, he is still more in their power under the per-case system, because they would have nothing to do but to direct the relieving officer to diminish the number of orders. But if the total amount is to be provided out of the consolidated fund, then there would be no individual interest to reduce the amount. But if this were done, the treasury would take the place of the guardians and provide some sort of check on the number of cases. I do not think you can ever expect Parliament to consent that it should be simply at the discretion of the party—I may say, without offence, the interested party. I am glad to have had this opportunity of meeting so many of you, and I am obliged to you for the information you have communicated. I will take this opportunity of saying, that in the correspondence I have had with Mr. Griffin, who has been the most prominent member of your body, I have been pleased and gratified at the business-like way in which he has dealt with the subject. This is not a mere question of feeling, for if we went into that we should never get out of it; but the question is, how we can best provide an improved system of medical relief for the poor? We want a scheme which will by its justice overcome opposition. That is my object. I do not, however, pretend to say that what I have heard has not very much modified the opinion which I entertained in regard to my own scheme, but still there are several points to which objections have been started, but with respect to which I still entertain my own opinions. Looking at the question practically, I think we have made some progress. Last May there was almost a doubt as to whether there was a grievance, but now the existence of the grievance is admitted, and considerable ingenuity has been displayed in devising a remedy for it. I do not think it would be well for me to say off-hand what is the impression which Mr. Griffin has made upon my mind, as I am only one of the Board, and must consult with my colleagues; but I may say this, that first with my own scheme, and next by the suggestions which have been offered, I think we have made such progress that I do not despair of justice being done. On the previous occasion I was represented by some of the papers as postponing my scheme, *sine die*. I did not say that. I do not think it right to lay any bill on the table of the House until we can get a far greater amount of unanimity of opinion on the part of those concerned than up to this moment has been obtained. There are, Parliament, the guardians, and yourselves to be consulted. In order satisfactorily to settle this question, we must agree upon some fair elements upon which the computation could be based. I will now say one word about my scheme, not to press it, but to show what I think it was desirable to take into consideration. I proposed a triple basis on which to settle the salary. First, the amount of the pauper population; secondly, the number of cases; and thirdly, a margin which could cover mileage and other local circumstances which should be taken into consideration. You will see by Mr. Griffin's table that the present amount of salaries is £150,000. Two of the elements which I take into consideration give £141,000. If, therefore, this scheme were worked out, it is impossible but that some improvement must take place in the total amount of salaries, if any attention whatever is paid to the third basis. I think any

basis of calculation should increase the present amount of the salaries. I think the third element of mileage has been left out of sight, and people have argued as if I suggested only the two other bases of computation, which would produce a sum rather less than you at present receive. Out of the 3,300 medical officers, not more than one-third have as yet sent me in their answers, and I think the papers put in to-day bring it up to one-half, leaving half the medical officers of the kingdom who have not yet replied. From the boards of guardians I have received four hundred and nine answers, that is not two-thirds, and of those we have only three giving a distinct approval, one hundred and fifty-one gave their partial approval, and two hundred and fifty-five say they are satisfied on the whole with the present system. Now no man can say that that is a state of things which would justify the President of the Poor-Law Board in bringing a scheme before Parliament. But a still further agitation of the question may produce a much greater unanimity even in the course of a few months; for, as I understand, you are much more unanimous now than you have ever been. I do not think there will be any chance of obtaining the whole amount from the Consolidated Fund. I think it is much more likely that the half which you now receive from that fund may be withdrawn, than the other half paid. As to the permanency of tenure, I must bring forward a measure which will be beneficial to all parties, and not beneficial merely to the medical officers; and I must say that I think that permanency of appointment would tend to produce negligence. There should, therefore, be some period at which his contract should cease as a matter of course, when, if found negligent, his services might be dispensed with without the annoyance and discredit of forcibly putting an end to it. Since Mr. Pigott's committee, there is nothing but absolute misconduct which can lead to the displacement of a medical officer. Let the period of appointment, therefore, be five, seven, or ten years. The appointment of two medical men in a district is objected to; but my object will be to introduce amongst you a certain amount of competition, which is the moving principle of private practice. Mr. Griffin says truly, there ought not to be two medical men in a district where there is not work enough for one; but my scheme contemplated nothing more than this, that each of these gentlemen should (where there is at present a medical gentleman for each of two small districts) circulate over the whole. The result would be, on the part of each of them, a more careful attention to the duties of the office. I know that it has been thought an imputation on your profession that I should introduce this; but all that can be said of it is, that I desire to introduce into the administration of medical relief to the poor exactly the same principle which is in existence with respect to private practice, and I do not wish to carry it one step further. It has been suggested that acreage should be substituted for mileage; and that is a suggestion which I will carefully consider. I shall be glad to receive any further suggestions, and, before I attempt to concoct any Bill, I shall give you the fullest notice. What I hope to do is, in the course of the present session to prepare a Bill (if we can arrive at a fair solution of the difficulty), lay it on the table of the House—without any intention, however, of attempting it this year. It may thus be printed and circulated in the shape of a Bill towards the end of the session; and, if it is duly considered during the recess, there will, next session, be no difficulty in carrying it. But if we attempt to do anything of the kind now, we shall, I feel sure, do more harm than good. The matter ought not to continue in its present state; and, if I continue in office, I shall use the best means in my power to put this question on a better footing, and to make such arrangements as will be satisfactory both to you and to the public."

The subsequent removal of Mr. Estcourt to another office in Her Majesty's Ministry has somewhat modified the aspect of affairs; yet, probably, not much, if we may draw inferences from the correspondence between the right honourable gentleman and Mr. Griffin, which was given in last week's Journal.

In regard to the principle on which the payment of Poor-law Medical Officers should be founded, some difference of opinion exists; but a plan has been proposed, which has to some extent at least received the approval both of Mr. Estcourt and Mr. Griffin. It was described by Dr. Wynn Williams, of Carnarvon, in the Journal for January 29; and, at the deputation, he brought it under the notice of Mr. Estcourt. The plan which he proposes is, to pay according to *acreage*, not according to *mileage*.

"Every medical officer should be paid a fixed salary (of not less than 5*s.* per case,) on an average of the number of cases attended during the last three years. Whenever a patient's name appears in two or more successive quarters, it should count as two or more cases. This should be the fixed salary for every union in England and Wales where the district does not exceed in extent 1,000 acres; and should be paid out of the consolidated fund. Whenever the population is spread over more than 1,000 acres and less than 2,000, an additional sum should be paid (not less than 2*d.* per case; it may have to be 3*d.* or even 4*d.*, but that is a matter to be decided by the Poor-Law Board). When the extent is more than 2,000 acres and less than 3,000, a further sum (2*d.*) should be paid; and so on for every additional 1,000 acres up to 15,000. Beyond this only half the sum (1*d.* per case) should be paid for every additional 1,000 acres. This latter charge will apply more particularly to unions situated in mountainous districts, or where, from other causes, the population is spread over a very large extent of country, and yet chiefly collected together in small hamlets. The acreage charge should be paid out of the funds of the different unions; in fact, it should be an union charge."

The advantages of this plan, as contrasted with that of payment by mileage, are said to include the following. It will relieve the medical officer, as well as other officers, of the labour of keeping an account of the distance of each patient from the residence of the medical officer. It is more fair than the mileage system; because, under the latter, a medical officer residing in the centre of his district would receive a smaller amount of salary than one living at an extremity, and still less than one living out of it altogether. The mileage system, too, it is urged, would be unfair toward the ratepayers, inasmuch as they would have to pay more to a surgeon living out of his district than to one living in it.

Mr. Griffin, in the pamphlet to which we have alluded, thus expresses his opinion of the plan of charging by acreage:—

"In consequence of the remarks recorded in a subsequent part of this report by Dr. Williams, and the reply of the president, I have been led to consider the subject of acreage, which, if calculated at one penny per acre, will realise the sum of £146,210, and remove the pecuniary objection to Mr. Estcourt's scheme, so far as districts are concerned. The question of acreage *versus* mileage is well worth considering, as it will entirely remove any cause of dispute relative to distance, which mileage or non-residence in a district may entail. A mileage or some other mode of computation will, however, be necessary for union houses."

The principle proposed by Dr. Williams has received the almost unanimous approval of the union surgeons in that part of the country in which he practises; and it certainly appears calculated to remove much of the difficulty which stands in the way of settling the question of payment. We place the matter before our readers for their consideration, and for the expression of their opinions; but we are sure they will join us in giving our best thanks to Dr. Williams for the interest he has shewn in the subject of the remuneration of the Poor-law medical officers, and for the trouble he has taken to endeavour to remove one of the great difficulties in the way of a settlement of the question.

Reports of Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Tuesday, February 22nd, 1859.

Sir Charles Locock, Bart., M.D., President, in the Chair.

THE CAUSES OF DEATH AFTER AMPUTATION.

BY THOMAS BRYANT, ESQ.

Mr. Bryant stated that his paper was based upon an analysis of 300 cases of amputation, collected from the records of Guy's Hospital. He had divided them into four classes; and although he had not thought it necessary to alter the ordinary division of traumatic amputations into primary and secondary, he had made some change in the division of the other forms; for it became evident, in the analysis, that the classing together of such cases as amputations for talipes, tumours, elephantiasis, deformity, and others of a like character, with those of diseases of the joints, a wrong result must ensue; and, practically, this was found to be the case. He therefore divided these cases into *pathological amputations* and *amputations of expediency;* choosing the latter term as more accurately expressing the reason for the operation, as limbs are removed for tumour, talipes, elephantiasis, and deformity, more from expediency than from necessity; and he therefore suggested the use of such a term until a better was proposed. The author then proceeded to an analysis of the table of amputations, including 167 pathological amputations, 33 amputations of expediency, 76 primary amputations, 24 secondary amputations. Having given in detail the analysis of each division, he summed up the whole in the following general conclusions:—1. In amputations of the extremities, taken altogether, 25 per cent. are fatal; 30 per cent. in the lower extremity, and 10 per cent. in the upper. 2. Amputations, as a whole, are fatal in the following order:—Secondary, 50 per cent.; primary, 43 per cent.; amputations of expediency, 30 per cent.; pathological amputations, 12·5 per cent. 3. In pathological amputations of the thigh, 18 per cent. are fatal, or 1 in 5·5; of the leg, 7·7 per cent. are fatal, or 1 in 13·0; in those of the foot and upper extremity, success generally follows. 4. In amputations of expediency of the thigh, 31·5 per cent. are fatal, or 1 case in 3·16; of the leg, 66·6 per cent. are fatal, or 1 case in 1·5; in those of the upper extremity, fatal cases are exceptional. 5. In traumatic amputations of the lower extremity, 60 per cent. are fatal; of the upper, 18 per cent.; and traumatic amputations of the leg are, at least, as fatal as those of the thigh. 6. Secondary amputations are more fatal than primary. 7. In amputations of the thigh for chronic disease of the knee-joint, 1 case only out of 7 proves fatal,* or about 14·5 per cent.; but for acute suppuration, a fatal termination is the rule. 8. In amputations of the lower extremity for tumours, 36 per cent. are fatal; in those of the upper, recovery may generally be expected. Having then given two tables, showing the different causes of death, and their proportions or percentages both to the fatal cases and the whole number of amputations, the author went on to the analysis of each division, and condensed the whole into the following conclusions:—

General Conclusions upon the Causes of Death in Amputations generally. 1. 25 per cent. are fatal; 30 per cent. of the lower extremity, 10 per cent. of the upper. 2. Pyæmia is the cause of death in 42 per cent. of the fatal cases, and in 10 per cent. of the whole number of amputations. 3. Exhaustion is the cause of death in 33 per cent. of the fatal cases, and in 8 per cent. of the entire amputations. 4. The following causes of death are fatal in the annexed proportions:—

	Of Fatal Cases.	Of Whole Number.
Secondary hæmorrhage	7· per cent.	or 1·66 per cent.
Thoracic complications	5·6 „	1·33 „
Cerebral do.	3· „	·66 „
Abdominal do.	1·4 „	·33 „
Renal do.	3· „	·66 „
Hectic do.	3· „	·66 „
Traumatic do.	7· „	1·66 „

Pathological Amputations. 1. Pathological are by far the most successful amputations; 12·5 per cent. proving fatal. Such amputations of the upper extremity are generally followed by success. Of those of the lower extremity, 15 per cent. terminated fatally. 2. Pyæmia is the chief cause of death, proving fatal in 43 per cent. of the fatal cases, and in 5·4 per cent. of all pathological amputations; and when fatal, as a rule, it causes death within fourteen days of the operation. 3. Exhaustion, either from the shock of the accident or of the operation, from hæmorrhage, or all three causes combined, is the cause of death in 33 per cent. of the fatal cases, or 4 per cent. of all amputations. 4. Secondary hæmorrhage is the fatal cause in only 9 per cent. of the fatal cases, and in 1·4 per cent. of all amputations. 5. Hectic, abdominal, and thoracic complications act equally as causes of death in 13 per cent. of the fatal cases, and in 2 per cent. of all amputations.

Amputations of Expediency: 1. 30 per cent. are fatal; but as amputations of the upper extremity are, as a rule, successful, the percentage of this operation upon the lower is much increased, 40 per cent. proving fatal. 2. Pyæmia is the chief cause of death, proving fatal in 60 per cent. of the fatal cases, and in 18 per cent. of all such amputations; and when fatal, as a rule, death takes place within fourteen days of the operation. 3. Death from exhaustion occurs in but 10 per cent. of the fatal cases; and some thoracic or renal complication, or carcinomatous infiltration, are fatal causes in the same proportion.

Primary Amputations: 1. 43 per cent. are fatal; 60 per cent. in amputations of the lower extremity, and 30 per cent. of the upper. 2. Primary amputations are more successful than secondary. 3. Pyæmia is the cause of death in 43 per cent. of the fatal cases, and in 16 per cent. of the whole number; and, when fatal, the symptoms appear, as a rule, between the seventh and fourteenth days after the operation, and cause death in the third or fourth week, and not during the first two weeks, as in pathological amputations and those of expediency. 4. Exhaustion is the cause of death in 32 per cent. of the fatal cases, and in 12 per cent. of the whole number. 5. Traumatic complications prove fatal in 15 per cent. of the fatal cases, and secondary hæmorrhage, cerebral or thoracic complications, about 7 per cent. each; renal disease proving a cause of death in 3·5 per cent.

Secondary Amputations: 1. 50 per cent. are fatal; 68 per cent. in those of the lower extremity, and 12·5 per cent of the upper. 2. Secondary amputations are more fatal than primary, by about 8 per cent. 3. Exhaustion is the chief cause of death, proving the cause in 60 per cent. of the fatal cases. 4. Pyæmia is the cause in 25 per cent. of the fatal cases; secondary hæmorrhage and hectic in the remaining 15 per cent.

Conclusions upon Pyæmia as a Cause of Death. 1. It is the cause of death in 42 per cent., of all fatal cases of amputations, and in 10 per cent. of all amputations. 2. It is the cause of death in the different forms of amputation in the following order:—*a*, in 70 per cent. of all fatal amputations of expediency; *b*, in 43 per cent. of all fatal primary amputations; *c*, in 43 per cent. of all fatal pathological amputations; *d*, in 25 per cent. of all fatal secondary amputations. In amputations of expediency it is the most frequent cause, and in secondary amputations the least. 3. In amputations for acute suppuration of the knee-joint, whether the result of an abscess discharging into the joint or otherwise, pyæmia is a more frequent cause of death than in amputations for chronic disease. 4. It is the general cause of death in amputations for talipes, elephantiasis, and tumours. 5. In primary amputations, and in amputations of expediency of the leg, it is a more frequent cause of death than in the same operations upon the thigh. 6. Upon the whole, pyæmia appears to be a more frequent cause of death in amputations through limbs the tissues of which are in a normal condition, and where a large surface of healthy bone is exposed. 7. In pathological amputations, and in amputations of expediency, pyæmia, as a rule, proves fatal within fourteen days; but, after traumatic amputations, the period of death is about the twenty-fifth or twenty-sixth day.

General Conclusions upon Amputations of the Thigh: 1. That 27 per cent. are fatal; of pathological amputations, 18 per cent.; amputations of expediency, 31 per cent.; primary amputations, 60 per cent.; secondary, 75 per cent. 2. In amputations of the thigh for chronic diseases of the knee-joint, about 15 per cent. are fatal, or 1 case in 7. 3. Amputations of the thigh for acute suppuration in the joint are generally fatal; pyæmia is the chief cause of death in these cases. 4. Exhaustion and pyæmia are causes of death in equal proportions, or in about 40 per cent. of the fatal cases; and in 10 per cent. of all amputations of the thigh. 5. Exhaustion is most fatal in primary amputations, and the least so in amputations of expediency. 6. Pyæmia is most fatal in amputations

* The fatality of the excision of the knee, according to Butcher, is at least 1 case in 5.

of expediency, and the least so in primary. 7. Primary amputations are, for the most part, fatal from exhaustion, 35 per cent. of the cases sinking from this cause, 15 per cent. from pyæmia, and secondary hæmorrhage and traumatic complications 5 per cent. each. 8. Exhaustion, pyæmia, and hectic are equally fatal causes in secondary amputations, proving fatal in 25 per cent. each.

Amputations of the Leg: 1. 37 per cent. are fatal; pathological amputations, 7·7 per cent.; amputations of expediency, 66·6 per cent.; primary amputations, 62·5 per cent.; secondary amputations, 66·6 per cent. 2. Amputations of the leg are 10 per cent. more fatal than of the thigh; the amputations of expediency and traumatic amputations being more fatal, and the latter more frequent. 3. Amputations of expediency of the leg are generally fatal, being twice as fatal as those of the thigh; pyæmia is the chief cause of death in 75 per cent. of the fatal cases, and in 50 per cent. of all such amputations. 4. In primary amputations, pyæmia is the cause of death in half the fatal cases, or in 32 per cent. of all such operations; exhaustion and visceral complications in about 8 per cent. each. 5. Comparing primary amputations of the thigh and leg together, they are equally fatal; but pyæmia is twice as fatal in amputations of the leg as in amputations of the thigh. 6. Half the cases of secondary amputations die from exhaustion; pyæmia and secondary hæmorrhage being fatal in 8 per cent. each. 7. Taking all amputations of the leg together, 42 per cent. of the fatal cases die from pyæmia, and 32 per cent. from exhaustion.

Amputations of the Upper Extremities: 1. 10 per cent. are fatal. 2. Pathological amputations and those of expediency are, as a rule, successful. 3. About 20 per cent. of traumatic amputations are fatal; 22 per cent. of the arm, and 16 per cent. of the forearm. 4. One-third of these fatal cases die from pyæmia; one-third from some traumatic complication; and the remaining third from secondary hæmorrhage or visceral disease.

Mr. Solly thought no one would dispute the utility of the paper. The statistics contained in it, however, extended over a great length of time, and referred more to the treatment of our ancestors than of the present generation. It must be borne in mind that many of those cases which were said to be fatal after amputation, would be fatal independently of that operation; and, although the amputation gave the patient a chance of life, yet that was all that could be said for it in such cases. It had been the rule in the hospitals with which he had been connected, never to make an amputation during an acute condition of the joint; as, unless that could be subdued, a fatal result might be expected. Some of the author's facts appeared to indicate that resection of the joint might often be adopted in preference to amputation.

Mr. Spencer Wells observed that, in a large proportion of the cases reported by the author, pyæmia appeared to have been the cause of death. He would like to ask whether in Guy's Hospital the deaths from this cause were more frequent in the new than in the old buildings. The method of ventilation in the new portion of that Hospital was not one which he should like to see generally carried out. The Hospital smell was very oppressive, and the air was hot and dry,—conditions which he considered likely to favour the increase of pyæmia. In Paris, at the Necker Hospital, there were some old-fashioned buildings, with small rooms, dark, and not well ventilated; not at all the kind of buildings one would think desirable for an Hospital. Subsequently some new buildings had been erected in connection with that Hospital, constructed on the most approved modern principles, as regards ventilation, heating, lighting, etc., and with much larger wards, similar to the new rooms at Guy's. But it was shown a few years ago, by M. Trousseau, that the mortality was greater in the new buildings than in the old. This was explained partly by the artificial system of ventilation, and partly by the fact of so many patients being in the same ward. He (Mr. Wells) would like to know if that was the case in the new portion of Guy's Hospital. He did not know whether operation cases had been put into the new building or not; but he thought the old buildings preferable to the new. He would like to know, too, how far the modes of wet and dry cleaning could be brought to bear upon the number of deaths from pyæmia, and what influence was produced by proximity to the dissecting rooms. He had been informed when at Strasburg, a few months ago, that at the Hospital there, the mortality from pyæmia was very considerable in those wards which were immediately over the dissecting room; and that after removing all operation cases to the opposite side of the building, pyæmia had almost disappeared. This fact, he believed, might throw some light upon the same class of cases in English hospitals, and might justify the objection which the governors of our old hospitals had to the proximity of the dissecting rooms to hospitals.

Mr. Birkett said that they had had no surgical cases in the new wards at Guy's Hospital at present, except some trifling operations: and pyæmia cases were almost unknown in them. Death had certainly taken place from pyæmia in one or two cases, but they were cases of simple wounds. It was a great pity, he observed, that the authorities of the different hospitals in London did not come to some arrangement to prevent the putting of surgical cases in the same ward where pyæmia cases had been placed. He wished that they had better sanitary arrangements in the metropolitan hospitals, and that the governors of hospitals would consult their medical officers more frequently upon such arrangements.

Dr. Barclay, in referring to the circulars issued from the Hospital Committee of the Epidemiological Society, for the purpose of securing returns as to causes of mortality from various medical officers in the different hospitals, etc., remarked that the returns actually furnished were so scanty and incomplete that they were practically of no value.

OBSTETRICAL SOCIETY OF LONDON.

Thursday, March 3rd, 1859.

Edward Rigby, M.D., President, in the Chair.

The minutes of the last meeting having been read and confirmed, the names and qualifications of fifty-nine practitioners were read as candidates for the Fellowship. At a later period of the evening, the ballot was taken, and these gentlemen were afterwards declared to be unanimously elected.

CASE OF MEMBRANOUS CROUP. BY R. U. WEST, M.D.

One evening, Dr. West was sent for to see a child, aged 8 years, suffering from advanced croup. He ordered an antimonial emetic mixture, and a blister to the throat. The vomiting which resulted, caused the expulsion of a large quantity of shreds of membrane, and a large piece which was evidently a cast of the trachea.

ON A NEW METHOD OF EXAMINATION OF THE TUMOUR IN CASES OF SUSPECTED CYSTIC DISEASE OF THE OVARY; WITH THE DESCRIPTION OF AN INSTRUMENT FOR EFFECTING THE SAME. BY GRAILY HEWITT, M.D.

The author commenced by showing the many questions which the physician or surgeon anxiously puts to himself when called upon to administer relief in cases of presumed ovarian cystic disease, and more especially the question which he has to consider as to the particular method of treatment to be adopted. Thus, a case of considerable enlargement of the abdomen may come before us in which the shape of the abdomen, the nature of the visceral displacement, the general symptoms and previous history of the patient, render it tolerably certain that a tumour connected with the ovaries is present. But it is extremely desirable that we should also be able to learn the exact nature of the ovarian tumour, and the presence or absence of complications, more especially if we have to decide whether ovariotomy or simply paracentesis and injection should be resorted to. Dr. Hewitt proposed, by means of an instrument which he names the "ovarian sound," to probe the interior of the cavity in which the fluid is contained. The instrument to be thus used consists of an ordinary cannula and trocar; but the cannula is provided with an India-rubber diaphragm, having a small perforation in its centre through which the trocar passes. The sound is a slender rod, composed of the same metal as the ordinary uterine sound, and, therefore, flexible, graduated in inches, and fourteen inches long. It is provided with a smoothly-rounded extremity, and is fixed in a handle of convenient size. The trocar and cannula having been passed through the abdominal wall, the trocar is withdrawn; the sound is then introduced through the cannula before the contents of the cyst have been allowed to escape, and the operator examines the interior of the cavity leisurely and safely.

ON TRANSFUSION OF BLOOD: ITS HISTORY AND APPLICATION IN CASES OF SEVERE HÆMORRHAGE. BY CHAS. WALLER, M.D.

Having given a historical introduction, Dr. Waller went on to relate a case in which he seems to have saved life by the operation of transfusion. The patient had a severe attack of flooding after labour, and when seen by the author was in-

sensible, the extremities and general surface were cold, the respiration was laborious, the eyelids closed, and no pulsations could be felt in the radial or carotid arteries. The first injection of two ounces of blood rendered the beat of the artery discernible; and after the introduction of an additional six ounces the patient rallied, and recognised her medical attendant. A little brandy was then given, and recovery gradually took place. The author concluded with a few remarks on the best mode of performing the operation.

In reply to some questions by Dr. Tanner, the author stated that he had resorted to transfusion altogether in five cases and that four had recovered. He also explained that though careful not to allow any air to pass into the vein, yet he did not think this occurrence would be always attended with those formidable results usually predicted.

Dr. Barnes observed that every one who had seen a woman perish from flooding must have been haunted by the regret that he had not been prepared with the means of transfusing. It was much to be desired that this operation should be brought to a state of practical perfection. There were yet, however, several points which required investigation. He was glad to learn from a letter from M. Brown-Séquard, that that distinguished physiologist contemplated delivering in London a series of lectures on the means of preventing death from asphyxia, in the course of which he (Dr. Barnes) trusted that the whole question of transfusion would receive a thorough elucidation. The experiments related in his *Journal de Physiologie* were replete with interest. The leading facts established were, that all the contractile and nervous tissues may recover their functions under the influence of blood charged with oxygen, and that the success of transfusion depended upon supplying blood-globules, charged with oxygen. It appeared that venous blood, bearing an excess of carbonic acid and less oxygen, was not so useful. The fibrine was of no use; and in order to obviate the risk of coagulation, it was better to remove it by whipping it out. By this process the red globules would also become charged with oxygen, and fitted for transfusion. Thus the objection to using venous blood, which was much more convenient to obtain, was removed. Amongst many deeply-interesting experiments, M. Brown-Séquard had shown, that by transfusing blood, the function of irritability in the muscles of an amputated arm might be restored many hours after separation from the body. In illustration of these views, Dr. Barnes cited seven cases of transfusion, related by Mr. Higginson, of Liverpool, in 1857. Two of these cases were perfectly successful, and it could not be said that the others died from the operation. In one, however, the operation was impeded by coagulation of the blood, and in two others it was stated that the blood was dark and sluggish. It was highly probable, then, that the mode adopted by Dr. Waller, of injecting venous blood direct was not the best, and he looked forward with extreme interest for the further researches of M. Brown-Séquard.

ON A CASE OF EMOTIONAL MONOMANIA RECURRING DURING SUCCESSIVE PREGNANCIES.

BY ROBERT DUNN, ESQ., F.R.C.S.

After making some general observations on the effect of bodily states upon mental manifestations, Mr. Dunn proceeded in the detail of a striking instance of the dominant power of emotional apprehension—the sheer dread of bodily pain—in upsetting the balance of the mind, in the case of an intelligent but highly impulsive and excitable lady, during the parturient state in several successive pregnancies. The patient was under Mr. Dunn's observation from 1848 until 1854, when she left London. She died eighteen months afterwards, and unfortunately no *post mortem* examination was made. In her first labour she underwent severe bodily pain and suffering; and the great fear of pain in prospect embittered the period of gestation in her four subsequent pregnancies, the dominant and depressing feeling of her mind constituting a kind of monomania. After the birth of her last child, favourably accomplished while under the influence of chloroform, the fear of death took possession of her, and she tortured herself with thinking of the pain and agony of the act of dying. It was in vain to attempt to reason with her; she became violent and excited at times, and it was necessary to have a female attendant from an asylum to take care of her. For the rest of her life she remained an invalid; her fears continued undiminished; and she became exhausted and attenuated to the last degree, until at length she sank, her perceptions remaining acute until the last hour of her existence.

MEDICAL SOCIETY OF LONDON.

Monday, February 14th, 1859.

W. H. Willshire, M.D., President, in the Chair.

HYSTERIA, CONSIDERED AS A CONNECTING LINK BETWEEN MENTAL AND BODILY DISEASE. BY W. CAMPS, M.D.

Dr. Camps's object was to draw attention to such forms of hysteria as present marked evidence of *psychical*, in addition to, or complication with, *somatic* affection. Until within a comparatively recent date, it had been the custom to consider mental disease, and apart from bodily disease, as unconnected with or independent of each other. But insanity is far more a bodily disease than has been hitherto considered; and in cases of this malady there is mostly, if not always, impairment of the proper healthy cerebral structure.

Dr. Camps gave a brief account of the hysterical paroxysm, which is almost, though not exclusively, confined to the female sex. It is, however, in the moral state and motives, that not unfrequently attend or accompany the severer forms of hysteria, that we may recognise without difficulty the approximation of this disease to some of the forms of mental disease. In severe cases of hysteria, amidst considerable general disorder, the nervous system being chiefly involved, the proper functions of the brain often become deeply affected. There is observed in such an increased susceptibility to impressions, a great rapidity of movements, together with a capriciousness of motives; the countenance indicates the alterations that take place in the feelings of the patient; and in the worst cases, the most amiable sentiments are observed to be converted into the most unamiable and repulsive. In some, there appears to be, at times, a complete metamorphosis of the whole moral character. This state of the disease becomes a subject of the deepest importance, more especially in regard to its moral treatment, so far as regards the imposition of personal restraint, or confinement of the patient; for nothing would be more injurious to a hysterical patient in this condition than undue interference with personal liberty. The functional activity of the spinal cord, as well as of the brain, may be morbidly diminished, or augmented, or perverted; and this latter state is especially the condition in hysteria. The perversion of the functional activity of the spinal cord is most marked in some cases, in which there is an extreme irritability of the cord at least, if not of the entire cerebro-spinal axis; and in the severer forms of the disease there doubtless exists an excessive irritability of the whole nervous centres; and it may be, of the entire nervous system, including even the nerves themselves. It might be assumed, that the irregular, convulsive, and impulsive actions of hysterical patients, depend rather upon some state of the blood, which alters its healthy relation to the nervous tissue, than upon any structural alteration of the proper nervous tissue itself.

During the last nine months, Dr. Camps had had under his care a somewhat severe and remarkable case of hysteria, which, he thought, was one that afforded him good reasons to conclude that it, and similar cases, present phenomena that clearly show a connection between mental and bodily disease. The subject of this affection was a lady, above 50 years of age, of a highly nervous temperament, who first came under his notice, presenting many of the ordinary characters of hysteria; but, as the disease gradually developed itself, this patient presented, in addition, many of the characters of a very protracted and aggravated case of this disease. There were paroxysms of choreic movements; at first, chiefly confined to the lower extremities, and to the left side of the trunk; these gradually affected, in a slighter degree, the upper extremities; being attended then with considerable paroxysmic palpitation of the heart, and heavy, laboured respiration. There supervened excessive restlessness of the body generally, so that, when out of bed, the patient was almost always in bodily action, seldom or never sitting, frequently not even when at meals; in motion whilst standing, and very frequently walking hurriedly about in various apartments of the house. This was followed by, and accompanied with, excessive talkativeness, so as to fatigue her companions. When remonstrated with, and requested to be silent, her reply was, "I must talk, for I cannot help it". The subject of her conversation was almost invariably herself, and her peculiar ailment and condition, and this ultimately assumed the form of intense selfishness or egotism. There was no derangement of the special senses, nor of the general cuticular sensation. The disease appeared to ascend gradually higher along the cerebro-spinal axis, and at length to reach the sensory ganglia, and the cerebrum itself; for certain *psy-*

chical phenomena presented themselves at times, bearing the closest affinity to those exhibited in some forms of mental disease. Commonly, the patient slept well during the earlier part of the night, and seldom or never complained of pain in any part of the frame. The faculties of perception and memory were unimpaired, as was the judgment also, in relation to all matters of business demanding close attention; the imagination was in too lively exercise at times, but the will appeared to have lost its controlling power over the current of the thoughts. The patient would frequently remark, "My thoughts master me; I cannot help thinking about myself; I seem at times to have lost the power to think of anything, or of anybody, besides myself." Frequently, but not always, there was great irritability of temper; and this would sometimes be expressed in words, and sometimes in actions. The will having lost its controlling power, the impulses arising from this state of excessive emotional sensibility, were occasionally expressed in very irregular and extraordinary phrases and actions of the body.

The view the author took of this case was, that it was mainly connected with the cessation of the menstrual function. Moreover, in this case, there was excessive irritation, possibly congestion, of the greater part of the cerebro-spinal axis, including at least the sensory ganglia at the base of the brain—a condition of parts sufficient to account for most if not for all the symptoms connected with the nervous system.

Dr. Camps concluded by a brief reference to the treatment of hysteria. The measures recommended were: 1. The use of such agents as improve the general health, and especially the general state of nutrition of the nervous tissue; 2. Of such agents as remove the exciting causes of the paroxysms; and lastly, of all such agents as are likely to act beneficially upon the mental state and condition of the patient.

MONDAY, FEBRUARY 21ST.

E. CANTON, Esq., in the Chair.

THE NATURE OF THE SYPHILITIC VIRUS, AND THE MODE IN WHICH IT ACTS. BY J. L. MILTON, ESQ.

The author began by remarking upon the peculiar tendency to ulceration which characterised syphilis, more than any other disease, there being no tissue capable of taking on this action in which it was not occasionally manifested. He objected to the forced comparisons between syphilis and the exanthemata, these being much more rapid in their evolution, and marked by a very different course; they ran through different stages, while, at the outset, no one could foretell the exact type a given case would assume. Neither did syphilis resemble poisoned wounds, which ran a still more erratic course, and always tended to assume a dangerous, uncertain, asthenic form of inflammation, over which art had considerable influence. He therefore argued that, in syphilis, there was a peculiar action set up; and then the question came, By what agent is this effected? The invariable answer was, a blood-poison—a term which had not even been defined, and which, so far as palpable proofs were concerned, was as purely a supposition, a symbol, as any of the old doctrines of the virus being an acid, an alkali, a ferment, worms, the result of a disagreement between the naturals and non-naturals, or any of the countless conditions with which vanity and dogmatism had ever encumbered medicine. It was difficult to understand what most authors meant when they used the term. Mr. MILTON therefore proposed to take for discussion the doctrine of Professor Miller, who had at least spoken clearly on the subject. This author distinctly says that "the virus enters the system through the circulation", and that "in the system a second zymotic process is established". He (Mr. Milton) reduced this doctrine to three propositions—1. That a diseased secretion, which might be called a virus, is conveyed from one person to some part of the surface of another; 2. That this results in the formation of an ulcer, which possesses the wonderful faculty of discharging its secretion two ways at once, out of the system, and into the blood; 3. That this secretion accumulates in the system till some accident conducts it up by the skin. The theories of its being a ferment or parasite received their due meed of attention. To this he (Mr. Milton) objected that, as the ulcer discharges from its surface, in the most harmless way, an infinitely larger quantity of the virus than is ever taken up into the system, absorption would be about the greatest blunder in such a case that we could attribute to Nature—an express arrangement, indeed, on her part, for the production of secondary symptoms. Absorption of the virus could only take place through the agency of the veins or lymphatics; and it was a question how far this was possible, without solution and digestion of the pus. An amount of pus, such as a very small chancre will yield, produces, when introduced into the veins, depression, anxiety, prostration, serious suppuration, and even death. The hypothesis, that the virus lurks in the blood, simply meant, in plain English, that a few globules of pus, or a few drops of serum, reside for months or years in the midst of an immense body of fluid undergoing such ceaseless change that perhaps one-fifth of its entire bulk is thrown off every twenty-four hours; that a poison fructifies for years in a highly vitalised fluid; and that, while the organism can throw off daily pounds of secretion by a natural process, it cannot get rid of a few drops of pus without disturbing the whole group of animal functions. There was no necessity to invent any such machinery as a blood-poison: small-pox and vaccination, while they did not communicate any lasting changes to the blood, impressed such alterations on the organism as to make it incapable of taking on the disease again. In hydrophobia, the poison had been considered to lurk in the same way as in syphilis; yet, though we had the most exhausting convulsions of the system, no specific change in the blood had ever been traced. Syphilitic chlorosis, often viewed as a proof that the virus had taken up its abode in the system, was simply a coincident effect of the action of the virus: moreover, it was not an inevitable result when no mercury was given. The author submitted that there was no proof that the secondary symptoms expend a virus; nor would such a fact, if granted, affect the question now mooted. If the virus were thrown off in this way, the most rational plan would be not to interfere with the efforts of Nature to eliminate it. When once domiciled in the blood, how did the mercury get at the virus? for the metal was insoluble; and experience had shown that, if forcibly introduced into the veins, it could not pass the capillaries in the lungs. All the experiments made by injecting foreign matters into the veins proved that the resistance of the organism commenced at once; that Nature's efforts tended to bar the passage against their entrance—not to absorb and eliminate them. Finally, he contended that it was possible to explain the phenomena of disease without resorting to the gross mechanical theories of humoralism.

ANNIVERSARY MEETING, TUESDAY, MARCH 8TH, 1859.

W. H. WILLSHIRE, M.D., President, in the Chair.

The Eighty-sixth Anniversary Meeting of the Society was held at the Thatched House Tavern, 12, St. James's Street.

ELECTION OF OFFICERS AND COUNCIL.

The following gentlemen were elected officers and Council for the ensuing year:—*President:* John Hilton, F.R.S. *Vice-Presidents:* R. Greenhalgh, M.D.; G. Owen Rees, M.D., F.R.S.; Sir John Fisher; R. Wade. *Treasurer:* James Bird, M.D. *Librarian:* W. A. Harrison. *Secretaries in Ordinary:* Thomas Bryant; F. W. Mackenzie, M.D. *Secretary for Foreign Correspondence:* T. Davidson, M.D. *Other Members of Council:* R. Barnes, M.D.; J. Birkett; I. B. Brown; John Cockle, M.D.; Victor De Méric; Thiselton Dyer; Francis Hird; G. Johnson, M.D.; J. Marshall; P. Marshall; W. V. Pettigrew, M.D.; P. C. Price; George Ross; C. H. F. Routh, M.D.; H. H. Salter, M.D.; J. L. Siordet, M.D.; R. Taylor; E. J. Tilt, M.D.; H. Walton; W. H. Willshire, M.D. *Orator for* 1860: John Gay.

THE ANNUAL ORATION

Was delivered by C. H. F. ROUTH, M.D., in the place of Dr. Lankester, who had been elected last year to the office of orator, but who was prevented by indisposition from performing the duty. Dr. Routh gave an interesting sketch of the origin and progress of medical societies in the metropolis, and concluded with calling on the members to emulate the example of Fothergill, Lettsom, and the other founders of the Medical Society of London.

THE FOTHERGILLIAN GOLD MEDAL

Was delivered by the President to A. T. H. WATERS, Esq., of Liverpool, for his Essay on the Anatomy of the Human Lung.

THE DINNER.

About forty of the members dined together at half-past six o'clock. Dr. Willshire occupied the chair. Among the guests were the President of the Royal College of Physicians, Professor Owen, Mr. Wentworth Dilke, etc.

Association Intelligence.

BRANCH MEETINGS TO BE HELD.

NAME OF BRANCH.	PLACE OF MEETING.	DATE.
Birmingham and Midland Counties. [General Meeting.]	Hen and Chickens Hotel, Birmingham.	Thursday, April 14th, 6 P.M.

SOUTH-EASTERN BRANCH:

SOCIAL AND SCIENTIFIC MEETINGS OF THE MEMBERS RESIDENT IN ROCHESTER, MAIDSTONE, GRAVESEND, DARTFORD, AND THEIR VICINITIES.

Social and scientific meetings of members of the South-Eastern Branch resident in Rochester, Maidstone, Gravesend, Dartford, and their vicinities, will be held on the undermentioned days:—

Friday, March 25th, 1859, at 3.30, at the Town Hall, Gravesend.

Friday, April 29th, 1859, at 3.30, at the Town Hall, Dartford.

The members resident in this district will be gratified by the attendance and assistance of any of the members of the British Medical Association.

James Dulvey, *Honorary Secretary.*

Brompton, Chatham.

Parliamentary Intelligence.

HOUSE OF LORDS.—Tuesday, March 15th, 1859.

MEDICAL ACT (1858) AMENDMENT BILL.

This Bill was read a second time.

HOUSE OF COMMONS.—Thursday, March 10th, 1859.

LUNACY.

The Solicitor General gave notice that he would move for leave to bring in a Bill to amend the law on Commissions of Lunacy.

Friday, March 11th, 1859.

VACCINATION.

Mr. Monsell wished to put a question to the Vice-President of the Committee of Privy Council of Education, with reference to the exercise of the powers vested in that Council for the protection of health. He must express a doubt as to whether proper precautions to prevent the spread of small-pox had been carried out; for he found by the returns that during the last sixteen weeks there had been more deaths from small-pox than there had been during the preceding eighteen months; and that, too, in the metropolis alone. It appeared from the return of the Registrar-General, that in twenty-seven counties of England and in the whole of Wales, this epidemic prevailed; and he wished to know if the powers given to the Government by the Act of last year had been carried out. It had been stated in another place, that something had been done to secure an efficient supply of lymph, and that certain recommendations had been issued to the poor-law unions; but he believed that the important power given of framing regulations which should ascertain the qualification of the public vaccinators in the different unions, and secure the services of the best, had not been carried into effect. The returns showed that out of 1,000 properly vaccinated, only three died from attacks of small-pox; but 150 out of 1,000 died of those who were improperly vaccinated. It was most important, therefore, that the best vaccinators should be obtained; and he wished to know what steps the Government had taken to secure that result.

Mr. Adderley said that the right honourable gentlemen was quite right in saying that small-pox had been exceedingly rife lately, and that the Act of last session had been introduced for the purpose of checking that disease; but he thought he could prove that the Committee of Privy Council had exercised to the utmost all the powers they had obtained under that Act. With respect to the issue of regulations to the boards of guardians, with the view of raising the qualification of the public vaccinators, he might mention that the Government were now issuing such regulations as could be enforced. There had been some little delay, because in the first instance it was necessary that some correspondence should take place between the Committee of Privy Council and the Poor-Law Board, in respect to the regulations which could be enforced by them. It was in the next place hoped that they could better carry out the regulations through the machinery of the Medical Council, called into existence by the Medical Practitioners' Act; but finding they could not very well carry out their object by means of that Council, they were now issuing the necessary regulations by which the Poor-Law Board insist that all future contracts which shall be made, should be made only with those whose names appear on the Register provided by the Medical Practitioners' Act, as having passed an examination before the proper authorities. They had also stipulated for returns of successful vaccinations, which would be made from time to time; and by comparing these returns with the number of births, they would be able to see where the deficiencies arose; and they would then send inspectors round to enforce the compulsory powers given under the Act. The reason why the Compulsory Vaccination Act was inadequate, was more from the want of persons whose duty it was to put the law in operation than from any other cause, and that had been remedied. There was another thing he might mention. In had been determined to establish ten depôts of lymph in the kingdom, and thus a constant supply would be always at hand. They had exercised the power of inspecting all the unhealthy towns—such as Conway and others—in which complaints had been made of the prevalence of epidemics, and the results of the inquiry had been very beneficial. When the report was presented to the House, he thought that it would show that the Government had done all that it was possible for them to do to provide for the efficient working of the Act. [*Hear, hear.*]

Monday, March 14th.

METROPOLITAN DRAINAGE.

Mr. Williams asked the honourable member for Bath, as a member of the Metropolitan Board, what steps had been taken by that Board with reference to the main drainage of the metropolis, particularly on the south side of the river.

Mr. Tite had very recently joined the Board, but he had obtained from the Chairman what he believed was a correct account of the present state of the works. On the south side of the river there were two systems of sewers—the high level and the low level. The high level sewer began at Clapham, and ended at Deptford; it was ten miles in length, and its estimated cost was £203,000. The contracts for this sewer had been concluded last week. The lower level sewer began at Putney, and ended at the same point as the higher one—Deptford; it was eleven miles long, and the contracts for it would be advertised in June next. The two systems of drainage on the south side of the river would end at the same point at Deptford Creek, where the contents of the lower sewer would be pumped into the higher one, and flow into the estuary of the Thames at Erith. On the north or city side of the river, there were three systems of sewers; one began at Hampstead, and ran for seven miles and a quarter to a terminating point on the river Lea. The cost of this sewer was estimated at £252,000, and it would probably be finished in twelve months. The second sewer began at Kilburn, and ended at the same point on the river Lea as the first—a distance of ten miles; it would be contracted for at the end of the year. The third system, being involved with the embankment of the Thames, would require a longer time in construction. All these systems meeting at one point on the Lea, the water would there be raised from the lower to the higher level, and run in a common conduit to the sea at Barking Creek. The works would, it was hoped, be completed in four years; the whole of the money, £3,000,000, had been advanced by the Bank of England, at 3½ per cent. It was estimated it would all be paid off in forty years by a 3*d.* rate on the metropolis, amounting to £150,000 in the present year; this was £10,000 more than the original estimate of the amount of the rate; and if it continued to increase in the same ratio, it was believed the £3,000,000 would be paid off in thirty, instead of forty years.

Wednesday, March 16th.

LUNATIC POOR (IRELAND) BILL.

On the order for going into Committee upon the Lunatic Poor (Ireland) Bill,

Colonel Greville, after urging various objections to the machinery and provisions of the Bill, moved to defer the Committee for six months.

Lord Naas said the objections had been discussed fully on the second reading of the Bill, which was founded upon the recommendations of a Commission. He reviewed these recommendations, showing the extent to which they had been adopted in the Bill, and stating the reasons for the non-adoption of one of the suggestions of the Commissioners.

Mr. J. Fitzgerald could not support Colonel Greville's motion, which would put an end to the Bill, being of opinion that there ought to be legislation upon the subject; and he recommended its withdrawal, in order that he might move that the Bill be referred to a select Committee, to be empowered to introduce a provision that the expenses of maintaining the lunatic poor in Ireland shall be raised by rates levied in the same manner as rates for the relief of the destitute poor under the Irish Poor Relief Acts. He argued at some length in defence of this proposition, and against certain portions of the machinery of the Bill.

Colonel Greville withdrew his motion; and Mr. Fitzgerald thereupon moved his amendment.

After considerable discussion, in which the amendment was strongly pressed by Irish members, Lord Naas reluctantly gave way; and the Bill was ordered to be referred to a Select Committee without any special instruction.

RECREATION GROUNDS BILL.

This Bill was read a third time, and passed.

Medical News.

BIRTHS, MARRIAGES, DEATHS, AND APPOINTMENTS.

** In these lists, an asterisk is prefixed to the names of Members of the Association.*

BIRTHS.

Hanks. On March 15th, at Mile End Road, the wife of *Henry Hanks, Esq., Surgeon, of a son.

Kearney. On March 12th, at Long Ditton, Kingston, Surrey, the wife of Edward Kearney, Esq., Surgeon, of a son.

King. On March 13th, at 7, Thurlow Place, Hackney Road, the wife of Wm. Talbot King, Esq., Surgeon, of a daughter, stillborn.

Ormerod. On March 15th, at Brighton, the wife of *Edward Latham Ormerod, M.D., of a daughter.

MARRIAGES.

Corbould—Wilson. *Corbould, George G., Esq., Surgeon to the Bristol Dispensary, to Elizabeth, youngest daughter of *John Grant Wilson, Esq., Surgeon, of Clifton, Bristol, on March 8th.

DEATHS.

De Mierre. On March 11th, at St. Leonard's-on-Sea, aged 18, Albert Turner, younger son of *Albert De Mierre, M.D.

De Morgan. On March 13th, at 51, Upper Seymour Street, aged 41, the wife of Campbell De Morgan, Esq., Surgeon.

Haliday. On March 5th, in Dublin, Marian Emily, eldest and last surviving daughter of the late William Haliday, M.D., of Clifton, county Down, Ireland.

Humble. On March 10th, Edward Charles, son of William E. Humble, M.D., of London Road, Southwark, aged 10.

Irwin. On March 9th, at 5, Ardenga Terrace, Monkstown, Ireland, Isabella, widow of Henry Irwin, M.D., Deputy Inspector-General of Army Hospitals.

Monro, Alexander, M.D., F.R.C.P.E., F.R.S.E., Emeritus Professor of Anatomy in the University of Edinburgh, at Craiglockhart, aged 85, on March 10th.

APPOINTMENTS.

*Rendle, E. M. Russel, Esq., elected one of the Surgeons to the Royal Eye Infirmary, Plymouth.

HEALTH OF LONDON:—WEEK ENDING MARCH 12TH, 1859.

[From the Registrar-General's Report.]

The deaths registered in London in the week ending last Saturday, declined to 1174, having been in the previous week 1215. In the ten years 1849-58, the average number of deaths in the weeks corresponding with last week was 1228; but as the deaths included in the present return occurred in an increased population, they should be compared with the average raised in proportion to that increase; namely, with 1351. Therefore the number of persons who died last week is less by 177 than the number that would have died if the average rate of mortality had prevailed.

The deaths referred to diseases of the zymotic class in the aggregate do not exceed the corrected average at the present time, while those caused by affections of the respiratory organs, chiefly bronchitis, pneumonia, and asthma, are 209, being 100 less than the average. On the other hand, though scarlatina (including diphtheria) has become less fatal, the deaths from it are still very numerous, those of last week having been 79, against 32, the average number of corresponding weeks. Nineteen of the 79 were from diphtheria, and occurred in sub-districts as follows:—Kensington Town sub-district, 1; Belgrave, 1; Cavendish Square sub-district, 1; Tottenham Court, 1; Islington East, 2; Hackney, 1; St. Clement Danes, 1; Goswell Street, 1; Finsbury, 1; Haggerstone East, 1; Bethnal Green, 1; St. Mary Magdalen, Bermondsey, 1; Leather Market, 1; St. Peter, Walworth, 1; Peckham, 1; Rotherhithe, 1; Plumstead, 1; and Lee, 1. Fourteen women died after childbearing. A labourer, aged 40 years, found in the public road in Paddington, died from destitution. One person died of intemperance, besides three of delirium tremens. Five nonagenarians died in the week, all widows, the oldest of whom was 95 years.

Last week the births of 970 boys and 894 girls, in all 1864 children, were registered in London. In the ten corresponding weeks of the years 1849-58, the average number was 1736.

At the Royal Observatory, Greenwich, the mean height of the barometer in the week was 29.881 in. On three days, the mean daily reading was above 30 in. The barometrical readings varied from 29·55 in. to 30·35 in. The mean temperature of the week was 45·7°, which is 5·4° above the average of the same week in 43 years (as determined by Mr. Glaisher). On Saturday, the mean temperature was 53·5°, which is 12·9° above the average of the same day. On that day, the highest reading in the shade was 58°, and the lowest was as high as 50°. The thermometer in the shade attained its highest point both on Sunday and Monday, viz., 59°, and it fell to its lowest on Thursday, 29·7°. The range of the week was therefore 29·3°; the mean daily range was 16°. The difference between the mean dew-point temperature and air temperature was 6·6°. The mean degree of humidity of the air was 78. The mean temperature of the water of the Thames was 47·9°. The wind blew on six days from the south-west. The rain-fall was 0·09 in.

SALE OF POISONS BILL.

The following petition has been sent from the Royal College of Physicians of Edinburgh:—

Unto the Honourable the Commons of Great Britain and Ireland in Parliament assembled,

The humble petition of the Royal College of Physicians of Edinburgh, incorporated by Royal Charter,

Humbly Sheweth,—

That your petitioners, the Royal College of Physicians of Edinburgh, have had under their consideration "A Bill to Regulate the Keeping and Sale of Poisons", presently before your Honourable House.

That your petitioners are of opinion that the numerous fatal cases of accidental poisoning render some such Bill very desirable.

That your petitioners are of opinion that the Bill now before your Honourable House will not check the evils it is intended to remedy.

That your petitioners are of opinion that persons who know nothing of the nature and effects of poisons, should not be allowed to sell them in small quantities; and they would therefore beg leave to recommend that no one, with the exception of wholesale dealers, colourmen, and drysalters, who

might be specially licensed for the purpose, should be allowed to retail poisons, unless they are druggists or apothecaries.

That your petitioners, observing that very many of the cases of poisoning, especially in the manufacturing districts, occur from the use of patent medicines containing poisonous substances, especially opium, are of opinion that the whole system of patent medicines requires revision; and that those which contain poisons should be subject to the same regulations as any other preparations of that poison.

Your petitioners therefore humbly pray your Honourable House to take the premises into consideration, and to amend the said Bill, so as to restrict the sale of poisons by retail to druggists or apothecaries, and to wholesale dealers, colourmen, and drysalters, specially licensed; and also to place the sale of patent medicines, containing poisons, under similar regulations.

And your petitioners will ever pray.

Signed and sealed in name, and by authority of the College. (Signed),

Alex. Wood, M.D., *President.*

POOR-LAW MEDICAL REFORM.

DEPUTATION TO THE LATE PRESIDENT OF THE POOR-LAW BOARD.

On February 24th, a Deputation of Poor-law Medical Officers, headed by Mr. Griffin, and accompanied by several members of Parliament, waited on the Right Honourable T. Sotheron-Estcourt, M.P., then President of the Poor-law Board, for the purpose of laying before him certain requests for an amendment of the law regulating Poor-law medical relief. From seventy to eighty medical officers of Unions were present. Mr. Griffin, having been introduced by Mr. Pigott, M.P., stated that he appeared as the Chairman of the Poor-law Medical Reform Association, on the lists of which 1648 members were enrolled. He then stated the requests of the Poor-law medical officers in the following order, commenting on each as he proceeded.

1. That the appointments of present and future medical officers, whether of the workhouse, district, or parish, shall be permanent, subject only to the general order of the Poor-Law Board, dated May 25th, 1857, (art. 5), and to the rules now in force as to good conduct, but they shall have power to resign on giving a reasonable notice, as is the case at present.

2. The qualification of future medical officers shall be double (medical and surgical) and of the class laid down in the 21st and 22nd Vict. cap. 90, but none of the present medical officers shall be removed for want of those qualifications, provided they be registered, as is now required by law.

3. That a uniform scale of payment shall be adopted throughout the entire kingdom.

4. That the salaries of the medical officers of workhouses, districts, and parishes shall be annually fixed at not less than five shillings and sixpence per head upon the average number of paupers in the receipt of relief in the first week of January, and the first week of July of the preceding year, where the guardians find the medicines, and six shillings and sixpence per head where the medical officer finds the medicines. That an additional sum per head shall be added to the salaries of not less than one shilling for each mile beyond the first mile, and two shillings for each mile beyond the first five miles a patient lives from the medical officer's residence. The mileage to be annually so computed that one rate of payment shall be made for all who reside in a workhouse, district, or parish, as the Poor-Law Board may decide.

That all patients annually attended by the medical officer, whose names are not included in the list of those in receipt of relief for the preceding year, shall be added to the average number recorded on that list, and the salary fixed for the succeeding year at the same rate as if they had been so recorded.

5. *For Workhouses.* A salary shall be fixed on a uniform and definite system, with mileage, where the distance of the house is above one mile from the residence of the medical officer.

6. *For Districts and Parishes.* A salary shall be fixed by the guardians, with the sanction of the Poor-Law Board, upon the following basis:—Not less than one shilling and sixpence per head upon the average number of persons in the parish in receipt of relief, in the first week of January and the first week of July in each year, upon an average of the last three years; and in addition to this, not less than one shilling and sixpence per case upon the number of cases attended in the district or parish, upon an average of the last three years, where the guardians find the medicines, and two shillings and sixpence per case where the medical officer finds the medicines.

7. That a fixed salary, founded on the average number of cases attended during the last three years, be adopted; the sum to be calculated at not less than 5*s.* per case.

8. In all the foregoing cases, whether of the house, district, or parish, an additional sum per case to be fixed by the guardians, with the sanction of the Poor-Law Board, shall be paid, of not less than one shilling for each mile beyond the first mile, and two shillings for each mile beyond the first five miles the patient resides from the medical officer's house; one journey in a quarter only to be charged for, if the per case payment be adopted.

9. The mileage to be so computed that one rate of payment shall be made for all who reside in a workhouse, parish, or district, as the Poor-Law Board may decide.

10. That a revision of salaries take place triennially in each union, if desired, either by the Poor-Law Boards of guardians, or medical officers.

11. A table of fees for midwifery and surgical operations, and a list of more expensive drugs and appliances, shall be drawn up by the Poor Law Board, with the advice of the General Council of Medical Education and Registration of the United Kingdom. Every medical officer appointed to attend any workhouse, district, or parish, shall, in addition to his salary or other remuneration, be entitled to his fee according to such table, after attending a case included in it; and any such medical officer shall be at liberty to direct any drug or surgical appliance included in such list, to be made up and supplied by some druggist, approved by the guardians, or their own dispensary, if they shall have established one.

12. In cases of attendance upon continuous sickness extending beyond three months, if payments be made by the case, each of such cases shall be considered, after every three months attendance, as a fresh case.

13. Orders for medical relief shall be given by the relieving officer in all cases where a poor person resides within two miles of his house, and by the overseer where the poor reside beyond that distance, and in all urgent cases, as now provided by law.

14. If the medical officer shall have attended a case represented to be of emergency and the person too poor to procure medical aid, and the guardians shall afterwards determine that the further attendance of the medical officer at the charge of the parish or union, ought not to be given, such case shall, notwithstanding, be reckoned and paid for according to the scale laid down.

15. That a medical man conversant with union practice, should have a seat at the Poor-Law Board, and especial control over the medical department.

16. That any medical officer who desires to remain under the present regulations may do so, if the Board of Guardians of his union and the Poor-Law Board are agreeable, but his successor in office shall come under the new regulations.

17. That should the salaries be fixed on the number of paupers attended, it is respectfully submitted that the same should be paid from the consolidated fund, in order that the whole kingdom may bear the burden equally; all other payments to be a union, and not a parochial charge.

Mr. Estcourt, in his reply, admitted the necessity for reform; and stated it to be his intention, if possible, to introduce a Bill which might be printed and considered during the recess.

TO CORRESPONDENTS.

POSTAGE OF MANUSCRIPT AND PRINTED MATTER.

Any amount of manuscript or printed matter, singly or together, provided it contains nothing in the form of a written letter, is transmitted through the post, in packets *open at the ends*, at the following rates: not exceeding 4 ounces, one penny; above 4 and not exceeding 8 ounces, twopence; above 8 ounces and not exceeding 1 pound, fourpence; for every additional half-pound or under, twopence.

Members should remember that corrections for the current week's Journal should not arrive later than Wednesday.

Anonymous Correspondents should always enclose their names to the Editor; not for publication, but in token of good faith. No attention can be paid to communications not thus authenticated.

Communications have been received from:—Mr. E. M. R. Rendle; Dr. F. J. Brown; Mr. W. B. Wall; Dr. Markham; Mr. G. Greaves; Dr. A. W. Williams; Dr. Brittan; Dr. W. Hinds; Mr. A. Prichard; Mr. H. W. Rumsey; Dr. S. M. Bemiss; Mr. H. Hanks; Dr. P. H. Williams; Dr. Styrap; Mr. J. C. S. Jennings; Dr. Russell; Mr. Milton: Mr. T. Holmes; Mr. T. M. Stone; Mr. Stevens; Mr. Howkins; Mr. Griffin; Messrs. Savory and Moore; Dr. E. Bennett; and Mr. J. Z. Laurence.